

Harvard Medical

ALUMNI BULLETIN

SPRING 1992



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Harvard Medical

A L U M N I B U L L E T I N



Cover illustration by Richard Goldberg.

17 Unsung Heroes

A letter to the Alumni Council from George S. Bascom '52 calls for recognition of practicing physicians.

18 Tales from the Trenches

by Richard J. Hannab

Reflections of a (usually) happy internist.

21 Cowboys and Other Characters

by George S. Bascom

Narrative sketches and poetry.

25 Neurology Far from the Madding Crowd

by Paul H. Altrocchi

After a long and varied career, the author moves to central Oregon's high desert coyote country.

33 Doctor Quixote

by Michael T. Myers

An '80s graduate walks away from his dream of private practice.

38 As Seen on TV

The private practitioner on television.

40 The Use of Force

A short story

by William Carlos Williams

41 The Youngest Science

Excerpt from the book

by Lewis Thomas

44 I'd Do It All Again

by Rial W. Cummings

The ups and downs of general practice in rural Montana and Silicon Valley.

46 Where Everyone Knows Your Name

by Craig Yorke

A physician's community in Kansas.

47 Shadowing

John Stoeckle and colleagues advance a technique for learning the "work of care."

48 The National Health Services Corps: To a Healthier Nation

by Donald Weaver

The 20-year-old program brings health care to those most in need.

DEPARTMENTS

3 Letters

5 Pulse

BCH alumni reunion, study finds visual abnormalities related to dyslexia, Second-year Show, two new chairs filled, NHSC announces openings, Christopher Walsh named DFCI president, Czech students visit.

9 On the Quadrangle

The Halloween incident: an open letter from the dean.

15 Book Marks

Transformations in American Medicine: From Benjamin Rush to William Osler by Lester S. King; reviewed by Eliska Atkins.

16 Alumni Council: President's Report
by George M. Bernier Jr.

52 Alumni Notes

63 In Memoriam

Gustave J. Dammin

64 Death Notices

This issue of the *Bulletin* is the Song of the Unsung Hero, long overdue. It calls to mind the picturesque words of Ecclesiasticus in praise of famous men "... that have left a name behind them that their praises might be reported. / And some there be which have no memorial."

After some carefully chosen words from the dean on student matters, George S. Bascom '52, our guest editor, sets the tone of the issue in his essay on the practicing physician, a letter to the Alumni Council on the occasion of his retirement from that body last year.

Richard Hannah '66 follows with tales from the trenches that defend the communities beyond the Pale north of Boston; then back to George as he introduces us to some consumers of health care in Manhattan, Kansas; and off we go with Paul Altrocchi '56 to the sylvan charms of Bend, Oregon, high contrast to the quixotic battle of Mike Myers '85, with the windmills of private practice in an underserved part of Boston.

After a short interlude with John Stoeckle '47, a short story by William Carlos Williams, and a sidebar with Lewis Thomas '37, we travel back to Montana and California's Silicon Valley with Rial Cummings '52 and to Topeka (where everyone knows your name), Kansas with neurosurgeon Craig Yorke '74. We end the tour by joining the National Health Service Corps with Donald Weaver '73.

It's a Grand Tour, and do not be surprised if the identifying photographs make your guides seem young, for you are looking at their graduation pictures, taken before the slings and arrows got at 'em.

Gordon Scannell '40

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Letters

Taking Issue

Was anyone else distressed by the talk given by Harvey Klein '63 and reprinted in the *Bulletin* (Fall '91)?

Regarding Klein's talk, I had the feeling that Libby Zion, whose privacy and humanity evidently aren't matters of concern to him, had some nerve dying and causing her physicians all that trouble.

Klein tells the world that this young woman had been treated with "psychiatric drugs." She was admitted to a very major teaching hospital late on a Sunday evening after being examined by three physicians, who had a probable total of five or six years of experience. These veteran doctors, who were into their 16th straight hour of work (a fact Klein considers insignificant) thought that the patient's behavior appeared to be under "volitional control." The physicians were astute enough to know that the patient required admission and to notify her personal physician, who evidently didn't find it necessary to personally evaluate a confusing case. After all, the diagnosis of "viral illness with hysterical symptoms" is a common enough reason for admission to New York Hospital, or is it?

The remainder of Klein's talk has to do with the perceived barbarities involved with quality assurance and peer review activities in New York State at present. Things will get better, Klein assures us, because the state doesn't have the money for quality assurance work, and besides, "a new commissioner of health will soon be chosen."

Too bad Klein didn't have the charity to mention the commissioner, David Axelrod '60, who was felled by a massive stroke at a time when much of what he did was improving chances that patients be treated appropriately in a state in which significant problems

have been publicized in such scandal sheets as *The New England Journal of Medicine*. Axelrod, it might be remembered, urged that the residents not be disciplined. He was overruled by the Board of Regents.

Klein is concerned about the "enormous psychological and professional damage done to the two young residents." Last I heard, one is a practicing physician in Palo Alto, while the other is an attending physician at, of all places, New York Hospital. In addition, they have been acquitted of charges of gross negligence by the New York State of Appeals.

Libby Zion remains dead, and as dishonored by medicine in death as she was in the last few hours of her rather short life.

Joseph R. Barrie '60

As a member of the New York State Department of Health Board for Professional Medical Conduct I feel entitled to submit this reply and follow-up to the stimulating Alumni Day address, "Destruction of the Temple," by Harvey Klein '63 and its subsequent publication in the *Bulletin* (Fall 1991).

The grossly unfair and judicially incompetent action of the New York State Board of Regents in overturning the decision of the health department's hearing committee and its commissioner—which exonerated the two resident physicians involved in the care of Libby Zion of all charges against them—was reversed by unanimous decision of the appellate division of the New York State Supreme Court, Third Department, handed down October 31, 1991. After unconscionable delay, the stain on the physicians' records and reputations has been erased, although nothing can reverse their emotional ordeal or legal expenses.

In addition to being aware of this belated dispensation of justice in this

particular case, readers should know of recent significant changes in the physician discipline process in New York. Legislation in effect since late July amended the public health and education laws, eliminating the power of the Board of Regents and of the commissioner of health to affect determinations of the Board for Professional Medical Conduct in physician misconduct cases. Hearing committee decisions are now final, with appeal possible to a review board consisting of three physicians and two lay board members. The right of further appeal to a higher court is preserved. This legislation also sets time limits for proceedings, which together with administrative changes in the conduct of hearings should materially shorten the entire process.

It is anticipated that these reforms will, without utilizing the approach proposed by Klein, achieve everyone's goal of making the New York physician discipline system quicker, fairer, better and less expensive.

J. LaRue Wiley '41

Klein responds:

J. LaRue Wiley brings us up to date on recent physician discipline reform in New York State. I agree that this is an improvement over the old system, but I still believe that a role for the medical schools would be a good thing.

Joseph R. Barrie raises many points:
1. Libby Zion's privacy was first breached by her father on talk shows, in city council hearings and in an "op-ed" piece written for the *New York Times*. In addition, a very complete and entirely different view of the case was published by M.A. Farber, a veteran investigative reporter for the *New York Times* in *Vanity Fair* magazine in 1989. The many licit and illicit drugs that Zion had consumed prior to her death are all in the very public record.

Letters

2. The thrust of my piece was not about "quality assurance" but about how the physician discipline process in New York State was abused, distorted and perverted because of the efforts of a well-connected lawyer and writer with access to the media and politicians.

3. I believe that I did mention that the health commissioner endorsed the findings of the hearing committee. I did not discuss David Axelrod's career and unfortunate illness because I did not feel either was relevant to my talk, which was too long anyway.

4. Barrie implies that no real danger could have been done to the two young residents, despite their unprecedented eight-year ordeal, because one is practicing in Palo Alto and the other in New York City. Would he be more sympathetic if they were practicing in less desirable geographic areas? (Massachusetts?)

Harvey Klein '63

Looking Back

I would like to tell a story that illustrates the humanitarian side of Walter B. Cannon.

It was during our first lecture in physiology in one of the amphitheatres that Prof. Cannon requested we not smoke. He went on to explain that the janitor who cleaned the hall was suffering from arthritis and the extra task of cleaning our cigarette butts aggravated his pain.

That I recall this incident after all these years illustrates the power of teaching by example. It may have been more effective in teaching students how to empathize with a patient than the courses that are now part of the curriculum.

Bernard German '40

Unforgettable

After reading "Learning from the Masters" by Carl W. Walter '32 in the *Bulletin* (Spring 1991), and further stimulated by Robert J. White '63, Cleveland's international neurosurgeon, I decided to share one of my most unforgettable memories.

When I arrived at Harvard Medical School in the fall of 1931, one of my most cherished desires was to see Harvey Cushing operate on the brain. Accordingly, when he had scheduled a case, I went to the operating floor at the Brigham and told the head nurse of my desire. Without asking any questions, she got me attired in a cap, gown and mask and took me to Cushing's operating room. When she opened the door, I was confronted with a patient lying on the operating table. About three feet away to the right was an instrument table. About three feet to the left was a prep table with Gil Horrax actively at work. Beyond, under the slanted windows letting in the daylight, was the viewing stand with a sheet draped across the front of it. A

straight line being the shortest distance between two points, I started toward the viewing stand going between the operating table and the instrument table so as not to interfere with Horrax.

I was about halfway through the slot before Horrax became aware of me. He turned and gave me the most brutal verbal dressing down that I can remember. If I could have conveniently dropped through a hole in the floor, I would have done so. Somehow they got me turned around and directed me around the edge of the room to the viewing stand.

Cushing came in and sat down with his back to the viewing stand. He then proceeded to remove a cerebellar tumor, four or five cm in diameter, with the Bovie loop. When he was finished, the middle cerebellar artery, completely free and undamaged, was traversing empty space. It was a feat of technical expertise I have not seen equaled.

As I was leaving the operating room, Cushing's chief resident, William Mahoney, stopped me and apologized for Horrax's words, saying everyone was keyed up and nervous before an operation. I very much appreciated his kindness in speaking to me. I had a letter of introduction to Horrax from his relatives in Montclair, New Jersey, but I could never bring myself to deliver it.

Philip F. Partington '35

Pulse

BCH Reunion

Boston City Hospital's first all-service alumni reunion is slated for May 22 and 23. The reunion begins with a dinner dance on Friday evening at the Copley Plaza Hotel. During the post-prandial program, alumni will take the floor with anecdotes about their years at the hospital. A "Clinical Day" at the hospital on Saturday will feature a series of discussions: "The Historic Role of Academic Medicine in Public Hospitals," "Plagues," "Health Care for the Poor," "Cocoanut Grove (50th Anniversary) and the Management of Burns and other Trauma at Boston City Hospital," "Vitamin B-12, the Nobel Prize and Hematology at Boston City Hospital," "Colon Cancer and the National Polyp Study."

The reunion celebrates the construction of a \$153-million, 356-bed inpatient facility, slated for completion in 1994. For more information, contact the Boston City Hospital Alumni Reunion Headquarters at (617) 534-3504.



Margaret Livingstone and Albert Galaburda

Pathway to Dyslexia

New evidence gives HMS faculty members reason to believe that dyslexia involves more than the system for processing language in the brain. They now suspect that in dyslexics there are also abnormalities in one of two pathways that transmit visual signals from the eye to the brain. Dyslexia is a language and reading disorder that causes learning problems.

The study was reported in the September 1991 issue of *Proceedings of the National Academy of Science*, by Margaret Livingstone, professor of neurobiology; Albert Galaburda, associate professor of neurology (neuroscience); Glenn Rosen, assistant professor of neurology (neuroscience); and Frank Drislane, instructor in neurology.

This study grew out of investigations of the visual system by Livingstone, whose work with David Hubel, John Enders University Professor of Neurobiology, and that of other researchers, indicated that the visual system is divided into two pathways. One pathway, consisting of magno cells, reacts quickly and is sensitive to motion and slight differences in contrast; while the other, slower pathway, consisting of small parvo cells, handles color and resolution of fine detail, and can only perceive high-contrast differences.

Livingstone had observed that images that stimulate only one of the two pathways produce unusual visual

effects, such as letters appearing to jump around—a symptom of dyslexia. She discussed with Galaburda, who heads the Dyslexia Neuroanatomic Lab at Beth Israel Hospital, the possibility that dyslexia could involve a dysfunction of the magnocellular pathway.

They launched a study of twelve volunteers—five with dyslexia, seven without—who underwent visual evoked potential studies. Dyslexics showed slower responses to low-contrast images, suggesting a delay in the magno system, which handles them. Galaburda then looked at autopsy slide samples of cells from dyslexic and nondyslexic brains. While parvo cells appeared similar in all the brains, the magno cells of the thalamus region were smaller than normal and somewhat disorganized.

The combined results suggested to the researchers that dyslexics seem to experience a slowing down of the usually rapid-reacting magnocellular system. Therefore, their ability to accurately coordinate and interpret visual signals is disrupted.

Livingstone notes that the visual tests administered in this study could eventually be used in diagnosis. The researchers are repeating the investigations in a larger study and continuing more basic studies in hopes they may lead to strategies for resynchronizing the two pathways.

Pulse

Way-Cool Class Show

In the spirit of those way-cool dudes from the California suburbs, Bill and Ted, the Second-year Show (with a commitment to diversity) sent Jill and Ted on an "excellent adventure" into the past to glean knowledge on how to save the future of medicine. This wacky duo had a most excellent time, and learned many cool and important things, as they travelled from the Beth General Women's Hospital in the year 2207 back to the marriage of Elio in 1723 Italy, and forward again into that way far out Age of Goodenough at Berkeley Medical School in 1969.

Along the way, Jill and Ted met some most bodacious characters: the Countway Monks and Attila the Hundert, who left his position as counselor to the Huns in search of adventure in Jill and Ted's time machine. After dancing with Farish Jenkins and *The Human Gait*, moving through the oral phase and sitting in for the renal review, Jill and Ted found the cure for the future of medicine at Harvard Medical School, where "After four years of this/ We can cure all... Forever and ever, hallelujah!" Party on, dudes and dudettes.



Top
Keenam Park as Elio
Raviola sings "The
Marriage of Elio."

Above
Time Traveler Ziporah
Cohen advises Jill
(Gretchen Schwarze).

Below
Dan Goodenough (Aaron
B. Caughey) sings with the
aquarians caught in a
time warp.



Two New Chairs Filled

Harvard Medical School has filled two new named chairs: *Andrew Warshaw* '63 is the first Harold and Ellen Danser Professor of Surgery; and *Allan Walker, MD*, the Conrad Taff Professor of Nutrition, HMS's first professorship in nutrition.

Warshaw, associate chief of surgery and acting chief of the MGH Surgical Oncology Unit, specializes in diseases of the pancreas. His work has included the evaluation of pancreatic cancer, surgical management of pancreatitis, and the analysis of enzymes related to pancreatic function.

"I chose to study the pancreas because it seemed a kind of mystery organ," he quipped. "One resident even told me that although he had never seen the pancreas, he still believed in it."

Most recently, he has been investigating injury to the pancreas following cardiopulmonary bypass surgery. He and colleagues have found that pancreatitis is often a hidden problem after heart surgery. Pancreatitis occurs when the pancreas is damaged by an "inappropriate release of enzymes," which can be caused by a blood flow problem, as might occur during a bypass procedure.

Warshaw pioneered the use of laparoscopy to help determine the stage and spread of pancreatic cancer, and is an expert on an unusual congenital disorder called pancreas divisum, in which two halves of the main pancreatic duct system do not join up correctly. He has also studied the world's largest series of cystic tumors of the pancreas, which are often malignant, and has established procedures for determining the cancer's stage.

Walker, professor of pediatrics and chief of the combined pediatric gastrointestinal and nutrition unit at Children's Hospital and Massachusetts General Hospital, is researching



Harold Danser and Andrew Warshaw, Harold and Ellen Danser Professor of Surgery

intestinal development in the fetus and infant. He says that the new chair will provide "the core facilities to do cellular and molecular research at the most sophisticated levels, to bring nutrition from the Middle Ages, where it has been, into the world of contemporary biology."

"This is the right time in the history of medicine to establish a Harvard professorship in nutrition," said Dean Daniel Tosteson '48 at the November reception celebrating the new chair. "We are now beginning to appreciate, with ever greater sureness and subtlety, how pervasive is the influence of diet on health and disease. It is a difficult field, needing both an understanding of molecular and cellular biology and the ability to conduct complex epidemiological studies."

Walker's research involves investigating the link between mother's milk and the infant's ability to protect itself

against infection outside the womb. While it has been known for many years that breast milk and colostrum contain antibodies to protect the infant from infection, Walker and his colleagues have shown that breast milk is involved in the development of the mucosal lining of the small intestine. This organ is where not only nutrients are absorbed, but also where antigens and disease-causing organisms are prevented from entering the bloodstream.

An immature intestine can result in neonatal necrotizing enterocolitis (NEC), which affects between 2,000 and 4,000 newborns a year and used to be 80 percent fatal. NEC occurs at a much higher rate in bottle-fed premature infants. Walker's studies support the idea that mother's milk might contain the steroids necessary for producing a mature mucosal lining: "It may be that steroids are naturally increased when mothers deliver prematurely, and that we can show a link between this treatment and a natural prevention of NEC," he says.

Another risk for the infant with an immature intestine is a susceptibility to food allergies. A lack of immunoglobulin A (IgA), a secretion of the mucosal lining, causes an increased absorption of antigens, leading to an allergic response by the immune system.

Finally, a new direction Walker hopes to investigate through the program is preventive diets for infants and children: "We don't know yet whether feeding babies too much salt or cholesterol in infancy leads to hypertension and heart attacks at age 40."



Allan Walker fills Conrad Taff Nutrition Professorship

The NHSC Way to Repay

The National Health Service Corps has openings for physicians completing residencies in internal medicine, pediatrics or family practice. Placements are for a minimum of two years and carry, in addition to salary, \$20,000 per year toward loan repayment. This enables loans with the highest interest to be retired, and makes it possible to carry the others with less difficulty.

Applications may be obtained from the following address and are due June 15, 1992.

National Health Service Corps
Loan Repayment Program
Bureau of Health Care Delivery and Assistance
Division of Health Services
Scholarships
Parklawn Building, Room 7-18
5600 Fishers Lane
Rockville, Maryland
20857

USPHS

Pulse

New President for DFCI

Christopher Walsh, PHD assumed the presidency of the Dana-Farber Cancer Institute, an HMS teaching affiliate, in January 1992. Walsh retains his HMS posts as Hamilton Kuhn Professor of Biological Chemistry and Molecular Pharmacology and department head.

Walsh succeeded Nobel laureate Baruj Benacerraf, HMS George Fabian Professor of Comparative Pathology Emeritus. Benacerraf served as DFCI president for 11 years, and will continue as president of Dana-Farber, Inc., the cancer center's parent company.

Arriving at HMS in 1986 from MIT, where he was a professor of chemistry and biology and chairman of the Chemistry Department, Walsh was the first chairman of the Biological Chemistry and Molecular Pharmacology, a merging of the biological chemistry and pharmacology departments. He is a Harvard University graduate, Class of '65, and he received his PHD from Rockefeller University in 1970. As a Helen Hay Whitney Foundation Fellow, he completed postdoctoral training in biochemistry at Brandeis University.



Photo by Barbara Steiner

Czech students visit HMS

Facing drastic changes in the delivery of health care in their country, the 14 Czechoslovakian medical students who visited HMS in January were especially interested in the U.S. system. The students, from Charles University in Prague, are part of an exchange program begun last year to compare experiences of faculty and students in the two schools. HMS students will visit Charles University in June. In addition to lectures and tours of Harvard-affiliated hospitals, Czech students and their HMS hosts spent an evening at the Boston Symphony and visited local museums.

Above, on a visit to Mass. General, are (left-right) the students' faculty advisor, Jiri Kraml, professor of biochemistry and vice-dean for basic science in Charles University's First Medical Faculty, Tomas Racek, Radana Sourkova, Jan Andrie, HMS second-year student Kevin Park, and Karel Raska, HMS clinical fellow in medicine at MGH, who led the tour.



Christopher Walsh is new president of DFCI.

Photo by David Witbeck

On the Quadrangle

The Halloween Incident

On January 8, 1992, Dean Daniel Tosteson sent out an open letter to the Harvard medical community, which we reprint here in its entirety. Since then, he has appointed the ad hoc faculty-student Committee on Racial and Ethnic Sensitivities chaired by Felton Earles, HMS child psychiatry professor and HSPH professor of behavior and human development.

Dear Colleagues,

This letter addresses the serious issues raised by an incident that occurred on October 31, 1991, in Vanderbilt Hall at the annual Halloween costume party and dance. I will describe what took place that night; the process that was followed to investigate and review the case; some of the social, professional, moral and ethical considerations which seem to me to be important in thinking about the event; and the actions that I have taken to move toward resolution of the matter.

In order to protect the privacy of students, it has been the policy of the School to inform only the students involved and the Masters of their Societies about actions taken in response to cases of this kind. In this and other recent cases, however, individuals involved in or aware of the event have spoken directly to the press. Since these individuals have sometimes had incomplete knowledge or a particular point of view, the resultant coverage has been, in certain respects, misleading. In order to provide members of the Harvard medical community with a fuller account of this important matter, I have decided to depart from previous custom and describe the incident and the process of review and appeals in some detail in this open letter. I will not, however, use the names of the individuals.

At about 10:40 PM that evening, two white second-year students — a man

and a woman — dressed as Clarence Thomas and Anita Hill, including faces darkened with makeup, were approached by a black first-year student, whom they had not met before, costumed as a "flasher" wearing shorts under a trenchcoat. The first-year student expressed his anger at the appearance of the second-year students. After brief heated comment, the first-year student knocked a beer container out of the hand of the second-year man (spilling beer over the dress of a nearby woman student) and left the party at the urging of two women students. While leaving, the first-year student told a Harvard University police officer that he was close to assaulting two people at the party because they were in "blackface." The police officer responded, "It's a Halloween party."

The first-year student went to the room of a friend who attempted to calm him. He then went to his own room and changed into sweat clothes. He returned to the party at about 11:15 PM. While he was away, a black woman in the second-year class explained to the two second-year students why blackface was so offensive. This conversation was still in progress when the male first-year student arrived at the dance floor, walked up to the male second-year student made up as Clarence Thomas, and after a brief verbal exchange, hit him with his right fist, opening a gash over the left eye. The first-year student assumed a boxer's stance ready to respond to any retaliation, but the second-year student did not hit back.

The HU police officer, who was nearby, seized and arrested the first-year student to prevent further blows. The first-year student did not resist constraint or removal from the Vanderbilt Hall dining room where the party was still in progress. He was charged with assault and battery,

booked, released on \$25 bail and arraigned the next morning, when he pleaded "not guilty." His trial will occur in February. It was later found that the first-year student had sustained a fracture of one of the bones in his right hand when he struck the blow. The second-year student was taken to the Emergency Room of the Beth Israel Hospital, where his wound was closed with 17 stitches.

On November 6, the two second-year students wrote an open letter apologizing to those made uncomfortable by their costumes. The Third World Caucus, an organization for minority students at the School, simultaneously issued an open letter expressing regret at the act of violence and the injury to the second-year student, but also pointing out that many were insulted by the sight of white students in blackface. Copies of both of these thoughtful and concerned statements are included as appendices to this letter.

The process for reviewing this matter followed guidelines for due process in the treatment of medical students who may have behaved in ways that are inappropriate for entry into the medical profession. These guidelines — adopted by the Faculty Council on March 13, 1987, and subsequently amended on October 15, 1990 — mandate that the Associate Dean of Student Affairs appoint an ad hoc committee (the Review Committee) comprised of three senior faculty members asked to



Photo by Bradford F. Herzig

On the Quadrangle

review a written record of the event, interview the student(s) and frame recommendations for the disposition of the matter. The students have the right to appeal the recommendations of the Review Committee. Appeals are heard by an ad hoc committee (the Appeals Committee) of five faculty members appointed by the Dean. Two of the five members of the Appeals Committee may be nominated by the student.

On November 6, after consulting with the

Ombudsperson, the Associate Dean for Student Affairs appointed the Review Committee, which met four times between November 12 and November 26. They surveyed a detailed statement of the facts assembled by the Associate Dean on the basis of written and verbal testimony by the involved students and witnesses. The Committee also interviewed the two second-year students, the first-year student, and two observers. Because of the pending criminal charges, the first-year student's lawyer was permitted to attend.

On November 27, the Committee rendered a unanimous report with

the following recommendations:

A

With regard to the first-year student, the Committee recommends that he:

1. be suspended from Harvard Medical School for one year effective immediately;
2. be required to spend that year in constructive work which carries no academic credit toward the MD or PHD degree;
3. be required to engage in a counseling program in order to understand and control his aggressive behavior;
4. be readmitted only if (a) he has a satisfactory work record without aggressive acts against others and

At the annual Cannon Ball on Halloween Night, we came as Clarence Thomas and Anita Hill. In our efforts to make our costumes as realistic as possible, we decided to use facial makeup. In our society, the imitation of African Americans by whites has historical connotations of a serious nature. We never made a connection between our portrayal of specific political personalities and the unfortunate connotations of black-face or any characterization of African Americans in general. We respect the feelings of those for whom the sight of a white in black makeup brings up unpleasant memories. We were saddened to learn that several of our classmates felt that the use of black makeup was inappropriate. Another student began to explain her feelings about the makeup; had we had the opportunity we would have removed the makeup and apologized at the time. We hope that those made uncomfortable by our costumes will accept our apology.

Thank you.

Appendix 1:
letter from second-year
students.

that this be documented in a letter from his supervisor to HMS, and (b) he gives permission for his counselor to provide to HMS an assessment of his progress and that his counselor certifies that he has made a sincere effort to deal with his problems and is ready to return to medical school;

5. he be readmitted on probationary status for the first-year of his return, during which he will be summarily expelled if he is found guilty of further misconduct.

B

With regard to the second-year students, the Committee recommends that:

1. they be informed that this Committee is appalled by their insensitivity to the feelings of their black classmates, and;

2. because they stated their action stemmed from ignorance and not malice, they be assigned the task of preparing by the end of this academic year a syllabus and bibliography on medicine in a multi-ethnic society for their own education and that of their classmates.

C

With regard to preventing further insults to the sensitivities of minority students, the Committee recommends that: the Dean charge a faculty-student committee with developing an educational program to equip HMS students with knowledge of and sensitivity to the characteristics of the disparate ethnic groups who constitute a significant part of the patient and health professional population with whom U.S. physicians will work."

These recommendations were accepted by the Associate Dean for Student Affairs and the Dean for Medical Education and transmitted confidentially in writing to the three students involved and to the Masters of

their Societies. On or about December 4, the first-year student indicated his intention to appeal. No actions were taken to implement the recommendations of the Review Committee pending the outcome of the appeals process. On December 11, I appointed two individuals nominated by the first-year student and three additional faculty members to an ad hoc Appeals Committee. The Committee met twice, on December 19 and 23, to consider all of the material made available to the previous Review Committee, additional written and oral statements from the first-year student and his attorney, and letters from several individuals and organizations commenting on the case. On the basis of these considerations, on December 23 the Appeals Committee unanimously recommended to me:

A

That the first-year student be informed that Harvard Medical School finds completely unacceptable his loss of self-control and that his inexcusable resort to violence is totally inappropriate for one who wishes to become a physician. The profession of medicine is an art and science based upon human compassion, and violence is therefore completely antithetical to this central foundation of medical practice. So contrary to medical behavior is an act of violence that any such act must receive the most severe expression of our community's condemnation.

B

That he be further informed that Harvard Medical School has seriously considered suspension and even asking him to withdraw from the School; but that, out of the same medical spirit of compassion to which his violence is so contrary, he is not being suspended, and will instead

receive the following sanctions as condition of his continuing as a student, with the additional strong recommendation that any further act of violence on his part during the remainder of his tenure at Harvard Medical School be met with immediate expulsion:

1. that he be placed on probationary status for a period of two years, beginning January 6, 1992, returning to good standing at the conclusion of these two years only if all of the conditions below have been met;

2. that he contact the Ombudsperson to arrange a meeting with the two second-year students for the purpose of resolution of the interpersonal side of this episode. The Ombudsperson will certify his completion of this requirement as a part of the conditions for terminating his probationary status;

3. that he engage in some form of community service as determined by the Dean, working with victims of violence in the community for 20 hours per month for the next 12 months. He is to coordinate this requirement through his Society Master, who will monitor it with him and will certify his completion of it at the end of the year as a part of the conditions for terminating his probationary status;

4. that he engage in a regular program of counseling, either group or individual, in order to gain control and achieve mastery over the impulses that led to an act of violence, which he told the Appeals Committee he knew is wrong, and also to understand better his immature interpersonal behavior.

In addition, this Committee would like to underscore the third recommendation of the earlier Faculty Ad Hoc Review Committee and urge you to take decisive educational steps to prevent further insults to the sensitivities of minority students. We join the Committee in the recommendation

On the Quadrangle

that you establish a mechanism for developing an educational program to equip HMS students with knowledge of and sensitivity to the characteristics of the disparate ethnic groups who constitute a significant part of the patient and health professional population with whom the students will work."

This incident raises important issues that have been sources of serious concern to many universities throughout the United States. I will address some of these issues in the context of the Harvard Medical School, a professional school preparing students for a lifetime of practice as physicians. I write not as a judge in a court of law determining guilt and punishment but as a dean concerned about the education and maturation of medical students.

Two sets of issues seem to me especially pertinent to this case: first, the tensions between the rights of freedom of expression on the one hand and proscription of behavior that is offensive to some groups on the other; second, acceptable responses to perceived harassment and, more precisely, when, if ever, physical violence is tolerable.

Universities bear direct responsibility for assuring freedom of expression and dissent. Their mission is to promote all kinds of learning. This mission can only be pursued in an atmosphere of open discourse free from the fear of harm for making controversial statements or even statements that deeply offend some members of the community. Presidents Bok and Rudenstine have in recent years re-affirmed Harvard University's commitment to this principle (which is formally articulated in the University-wide Statement on Rights and Responsibilities) in the light of certain statements or other forms of expression which were deemed by some to be so offensive as to require proscription. In

his open letter just two months ago, President Rudenstine emphasized not only the right of free expression but also, "the need to build a community free of intimidation and harassment, and based on respect for individuals as well as a desire to learn from others."

This need is particularly great in the Faculty of Medicine, which has for more than two decades pursued an aggressive program of affirmative action designed to increase the numbers of women and members of under-represented minority groups in the student body and faculty. In the years since 1969, Harvard Medical School has graduated almost 500 minority physicians, more than any other private, non-minority U.S. medical school. On June 6, 1990, Dr. Louis Sullivan, Secretary of Health and Human Services, called Harvard Medical School's affirmative action plan "... a blueprint for other medical schools, indeed all university programs." We remain committed to these goals and to meeting the responsibilities of having a diverse community. As our community has become more diverse, concerns about issues of harassment on the basis of sex, race, religion and ethnic origins have intensified. In 1990, the Faculty Council adopted guidelines defining harassment and recommended the appointment of an Ombudsperson. This position was filled in June of 1990 with an individual who helps to resolve disputes of this kind.

Concern about freedom of expression on the one hand and sensitivity to perceptions of harassment on the other are especially important for physicians. As part of their illness, some patients express themselves in ways that can be offensive to their physician. Moreover, illness heightens the tendency of patients to take offense at the actions of the doctors. Physicians need to learn how to manage these feelings of

offense in ways that benefit their patients. This is never easy since the feelings are often conflicting and very intense. The relationship between doctor and patient should encourage open and honest expression within a framework of mutual respect.

In addition to the tension between freedom of expression and freedom from harassment, this case raises the issue of physical violence in the Medical School. The use of violent force is acceptable only as a last resort to stop physical injury. It is particularly egregious for physicians to resort to violence when they feel offended. It is the very opposite of the Hippocratic injunction to "Do no harm" and is expressly prohibited by the University-wide Statement on Rights and Responsibilities. Moreover, its use effectively precludes efforts to identify and resolve the misunderstandings which lie at the root of such feelings. There are many avenues available for countering offensive speech or dress, but inflicting physical injury is not one of them.

With these reflections in mind, I have reached the following conclusions about this case:

The second-year students who attended the Halloween party costumed as Clarence Thomas and Anita Hill had a right to dress as they did. They were explicitly protected by the University-wide Statement on Rights and Responsibilities. Although their costumes offended some, they did not threaten any individuals. Moreover, their behavior should be compared with that of others who attended the Halloween party made up as Senator Edward Kennedy and Mary Jo Kopechne, or "Long Dong Silver" (after the porno star), or another Clarence Thomas (face not darkened), or a "flasher." The facts persuade me that they did not intend to offend →

The incident that occurred at the annual Cannon Ball Dance, in which a student struck another student who was in black-face costume, has created a great sense of despair in our communities of color and throughout the Harvard Medical area. Although many of us were undeniably upset by the black-face portrayal of African-Americans by two of our white classmates, we cannot condone - either as future physicians or as people of color - the use of violence as a means of settling a dispute such as this one. We deeply regret that this act of violence occurred and that one of the students in black-face was injured, and we have expressed our heartfelt concerns to him in numerous personal communications.

We feel that it is important, however, to discuss why this incident occurred so that similar conflicts can be avoided in the future. Many of us were insulted by the sight of white classmates in black-face portraying people of African descent. The nerve that this incident exposed is rooted in a long and painful history in which white individuals, often under the guise of comedy, have donned black make-up to belittle and denigrate African-Americans. These demoralizing, stereotyped characterizations were typified by popular American television shows and movies such as "Amos and Andy" and Al Jolson in his infamous "Mammy." It is troubling to us that many of our colleagues are either unaware of this history or insensitive to the issues that a black-face costume raises in a diverse community.

Moreover, we feel that the incident reflects a lack of understanding about racial and cultural differences in our society. Because each of us must work with patients whose racial or cultural background is different from our own, such a lack of understanding is cause for alarm. It is imperative that we, as future physicians, be prepared and comfortable with dealing effectively and emphatically with a racially and culturally diverse patient population.

In attempting to sort out many of these issues, it is necessary to separate the racial insult from the inappropriate response initiated by one medical student. While we realize that it is impossible for us to change what has happened, it is possible and important for us to address the tension and misinformation which exists on this campus. Workshops may be effective in dealing with many of the emotions that are associated with this incident. In addition, it is critical that a structured and comprehensive approach be taken each year, i.e. thorough consideration and discussion of cultural and racial issues must be incorporated as a standard and significant part of the medical curriculum (as has been done at other medical schools around the country). This two-pronged approach is necessary to train Harvard Medical School graduates to deal more humanely with these issues and to provide the best care possible to patients.

It is our hope that we can all come together to address these issues in a constructive manner. Again, we join the rest of the Harvard community in hoping for the full recovery of our injured colleague.

Sincerely,

The Harvard Medical School Third World Caucus

On the Quadrangle

but acted out of ignorance of the sensitivity of their fellow students and readily engaged in a discussion with them about the appropriateness of their dress and make-up.

Nonetheless, it is evident that many people of different races inside and outside the Harvard medical community were gravely offended by the blackface aspect of their costumes. (See appendix 2.) This reaction contains an important lesson for the two second-year students about the sensitivities of their colleagues, a lesson I believe that they have already begun to learn. Promptly after the incident they issued a public apology to all those whom they offended. (See appendix 1.) They have indicated their willingness to talk with all concerned. They have already learned a lot about the history of blackface in America. In the future, I trust that they will consider carefully the impact of their actions on others before they engage in caricature or satire of people from a particular ethnic group. I urge them to engage actively in the process of healing which we must now begin.

With regard to the first-year student who struck the blow, the costumes of the second-year students did not make it right for him to strike and injure a fellow student. However, I recognize that he acted in rage and that he has not made violent attacks of this kind in the past. I have searched for a response that will assist him to understand and feel the gravity of his mistake and to learn how, in the future, to help rather than hurt those who offend him. I think that the approach suggested by the ad hoc Appeals Committee is most likely to achieve this result. Accordingly, he will be placed on probation on January 9, 1992, for a two-year period under the conditions specified in the report of the ad hoc Appeals Committee cited above.

Finally, this incident — and particularly the subsequent reactions, commentary and debate — illuminate a schism in our community. I mentioned above our ongoing efforts to increase racial and ethnic diversity among our students and faculty. This case shows that this trend has worked not only in the direction of building greater respect, understanding and trust among individuals from different backgrounds, but also seems to have intensified suspicion of one group about the motives and goals of another group. The latter result is basically unintended and reflects feelings of which members of different groups are often unaware. In the words of one of the students, “We all need to talk.”

Both the ad hoc Review Committee and the ad hoc Appeals Committee recommended strongly that the School begin educational programs to increase the understanding of students and faculty members of the sensitivities of minority groups. I accept and support these recommendations. But I also believe we must recognize that definitions of harassment are likely to remain controversial, that there is unavoidable tension between the right to freedom of expression and the right to freedom from harassment, and that physical violence in response to perceived harassment poisons the effort to understand and resolve these tensions.

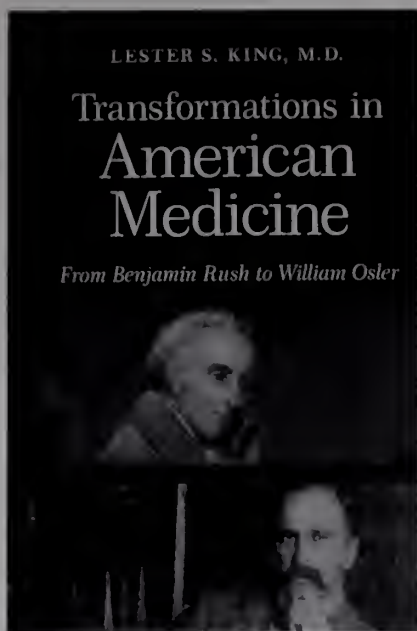
Accordingly, I will shortly appoint an ad hoc faculty-student Committee on Racial and Ethnic Sensitivities to study these inter-related issues and how educational programs at other institutions have addressed them. This committee will include a student and a faculty representative from each of the Academic Societies. In addition, I have asked each Society Master to convene immediately a student-faculty seminar directed toward the design of new components of the curriculum to

address these issues. The report of the ad hoc Committee on Racial and Ethnic Sensitivities will be made available to each of the Society seminars.

I hope that each of you will participate in this effort to transform the travail of the past weeks into deeper understanding of how to live respectfully and peacefully, as physicians and medical scientists, in a racially and ethnically diverse society.

Sincerely,
Daniel C. Tosteson

Book Marks



TRANSFORMATIONS IN AMERICAN MEDICINE: FROM BENJAMIN RUSH TO WILLIAM OSLER, by Lester S. King, Johns Hopkins University Press, 1991.

by *Elisba Atkins*

In this attractively produced book, Lester S. King, a veteran historian of 18th century medicine, turns his attention to the transformation that occurred in American medicine during the 19th century, as illustrated by the changing concepts of fever.

Starting with Benjamin Rush, a student of the 18th century physician William Cullen, King traces the evolution of the concept of fever, in particular that of the so-called "continued fevers," also known as "typhus fever" (which includes both the typhoid and typhus fevers of today). The problem of typhus puzzled the practitioners of medicine throughout most of the 19th century, until the advent of germ theory and the publication of Robert Koch's postulates, which preceded the work of William Osler, the endpoint of King's survey.

One of the benefits of King's analysis is his ability to put the reader in the intellectual milieu of the period in which these physicians worked. Broad concepts such as "rationalism" and "empiricism," as well as words like "hypothesis," "causes" and "facts" change meaning over the period. At the same time, the search for adequate evidence becomes more discriminating and the value of confirming hypotheses by experiment becomes established.

Certain figures such as the American country practitioner Nathan Smith and Pierre Louis at the three great hospitals in Paris emerge as leaders of this new thinking. Smith used epidemiologic data to establish the uniqueness of typhoid (versus typhus) fever, and Louis meticulously correlated patient histories with specific pathologic findings in his large series of cases, and compared these with other unrelated cases of illness.

By contrast, King shows us that others, like the French physician Broussais, although contemporary and influential, denied the specificity of disease in his system of physiological medicine and took refuge in outdated verbal solutions such as "sympathy" and "irritation," or other then poorly defined terms like "inflammation," to explain the phenomena of fever, but failed to provide well-documented histories or careful postmortem evidence for his cases.

The search for specificity in cases of continued fever was, of course, only finally resolved when separate bacterial causes were established and earlier concepts of "contagion" and "miasma" were superseded. Nevertheless, clinicians like Sydenham in the 17th century had argued for the uniqueness of various febrile diseases, and in the 10th century the Arabic physician Rhazes had recognized measles and smallpox as different entities. The category of

"essential fever" (in the absence of any obvious evidence of inflammation), however, continued to be recognized through much of the 19th century as an illness *sui generis*.

Rush was one who denied the specificity of fever, which he described as "due to morbid excitement of the blood vessels." This concentration on what we see now as the mechanisms involved in the elevation of body temperature (much of it correct in physiologic terms) directed attention away from the distinctive clinical and pathologic aspects of these fevers, typhoid and typhus, reflecting their different bacterial causes and epidemiology.

The success in discriminating between essential fevers (earlier separated into intermittent, remittent and continued categories) was aided by the new sciences of microscopy, bacteriology and clinical pathology and characterized the progress of 19th century medicine. This success is evident in Osler's classic textbook written at the end of the century when it is compared with Cullen's classification of fevers from a century earlier.

Using many examples, King's book is lively and illuminating, informal in style, and focused in its attention to the evolution of the different modes of thinking that separated the 18th and 19th centuries, as the science of medicine advanced conceptually and technologically. Earlier lists of what we now know to be symptoms of illness were gradually replaced by the discovery of specific causes of diseases.

One major contribution King omits is the long essay on fever by Osler's associate William Welch, who appears in another connection in the book. Written in 1888, this treatise presents a remarkably prescient explanation of both the mechanism and purpose of fever—one that has been largely confirmed by experimental studies on the

President's Report

by George M. Bernier Jr.

pathogenesis of fever during the past 50 years.

Welch's paper was the first to supply a satisfactory explanation for the similar febrile responses produced by different agents of infectious disease, a feature that had led Rush and others to postulate that fever itself was a single disease with various "states" of activity. It was no accident that its author was a professor of both bacteriology and pathology who based his work on extensive experiments of his own and of his contemporaries, reflecting the major shift in the approach to disease that had taken place during the 19th century.

The great merit of King's book is the clear and compelling way in which he presents the many facets of this transformation and its effect on previously accepted modes of therapy such as bloodletting.

Elisba Atkins, MD is professor emeritus, Yale University Medical School, and director of Habitat Institute for the Environment in Belmont, Massachusetts.

For at least a decade, a highly desired but unfortunately quite unrequited love of the Alumni Council of the Harvard Medical School Alumni Association has been to develop an alumni network to serve multiple purposes for students and new graduates. As envisioned, given the far-flung geographic distribution of Harvard medical alumni, the network could provide a contact point for new graduates of the school as they begin residency programs in hospitals removed from Boston. This network could also provide a contact for fourth-year students as they do electives outside of Boston and/or interview at residency programs not affiliated with Harvard.

Efforts have been made in the past to institute this kind of alumni network with limited but notable success. Paul Ramsey '75 has established a contact program in Seattle, which has provided safe haven for fourth-year students and beginning residents, and an entre to the Harvard medical community in Seattle.

A committee of the council chaired by Lisa Guay-Woodford '83—and consisting of Bernard Godley '89, James O'Connell '82 and Nancy Rigotti '78—has developed a mechanism for implementing such a program, with the goal of getting it in place in time to accommodate next year's senior class. It is the committee's hope that this network will eventually adopt additional student-oriented functions.

The database will be derived from a short questionnaire sent to alumni outside eastern Massachusetts. When you receive this brief request for information, I urge you to respond. It is not a solicitation for money, but an invitation to interact with HMS students at an important time in their lives.

A second major activity of this year's council has been participation on

the HMS Task Force on Financing Medical Education. The task force, which includes several prominent bankers, business people, investors and distinguished alumni, has met with students at varying stages of medical education to garner their perspectives on the impact of debts on residency and career choice. It has met with Dean Daniel Tosteson '48 for his perspective, and is attempting to structure a series of recommendations that will contain some novel approaches to debt-containment and/or forgiveness.

It is evident that our nation is attempting to deal with many problems surrounding health-care delivery, including limited access to health care and spiraling health-care costs. Expanded state and national programs that would provide debt forgiveness in exchange for service in underserved areas would seem to be a natural.

George M. Bernier Jr. '60 is dean of the University of Pittsburgh School of Medicine.

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Unsung Heroes

THE ALUMNI COUNCIL HAS BEEN repeatedly challenged by Will Cochran '52 to recognize the Harvard Medical School alumni who are practicing physicians. I cannot escape the sense of having failed Will as well as that distant silent constituency of which I am the only representative on the council. We practicing physicians have a perspective different in degree from the research scientist or academic physician that needs to be articulated.

The practicing alumni are the faces you cannot see. We sit in darkness before the beautiful and impressive transparencies when you lecture to us. We are not stupid, though we often feel that way in the presence of academic physicians. We are the ones through whom the marvelous gifts of science are made available to our patients.

We don't discover much in the way of scientific knowledge. We try to understand the individual patient and help him in his misery. Our discoveries are the small, local ones of diagnosis. Our advances are the simple ones of recovery by sick people to better health. Our lectures are to patients and their families. They are elementary, poorly illustrated and largely forgotten. Our rewards are the gratitude of people we help, the fees we collect and the satisfactions of competence.

We are busy answering the phone at home, running to the emergency room to suture lacerations, operating and making rounds on our patients and living with our problems and complications until the patients get well or die. When they die, we go to the hospital or home or nursing home to lay our stethoscopes on them for the last time. We talk to the family and then drive home wondering if we could have done better and thinking about our own brief lives. After they die, many of us write notes of condolence or go to the

Near the end of his term on the Alumni Council last year, George S. Bascom '52 wrote this letter to then-president Robert Goldwyn '56, calling for recognition of the silent majority — alumni who are practicing physicians.

funeral. If they happen to be old acquaintances, we mourn them. When we fail them, we feel guilty.

Our patients sometimes hore us, and we know boredom is dangerous, a good way to miss a colon cancer or a breast lump. We get very tired sometimes but have an office full of patients to see. Sometimes when we tackle something at the limit of our capabilities, we get scared.

If a patient dies, we have to explain it to our peers. We have to present our complications and accept criticism from others, usually constructive, often painful.

Many of us are faced with family problems: marital discord, alcoholism, suicide, disappointing kids.

We fear lawsuits and detest lawyers because they are often so pitiless and deliberately malicious. We suspect each patient a little and feel wretched about doing so.

We are frequently called to task by retrospective reviewers who have the

advantage of hindsight and neither responsibility for care nor often expert knowledge in our field.

We have offices to run, people to hire and sometimes fire, taxes to pay, regulations to meet, accountants and lawyers to consult.

The practicing doctor is not whining about his lot. He or she chose it or was forced into it by lack of academic qualifications. But Will is right in wanting the practitioners recognized. Theirs is a vital contribution, and they lead lives often embattled by stress, over-expectation and fallibility. Each year, perhaps, the council might recognize one practicing alumnus or alumna. Candidates might be offered by class agents and screened for selection by a committee of the council and chosen by vote of the council. The council can broaden Harvard's reputation for excellence to include excellence in the practice of medicine.

Issues of great importance to the practicing doctor—stress, failure, marital and family life, money management, peer relations and peer review, legal hazards, and human mortality—deserve recognition and address in medical school preparation.

In my immense respect for those of you in academic medicine, I am sure I reflect the feeling of my compeers in private practice. But my great respect for our alumni in private practice leads me to take advantage of the accident that gave me a seat on this distinguished council to add my voice to that of others in their praise. I would have felt derelict to have left the council without making these suggestions on their behalf.

George S. Bascom '52, a surgeon in Manhattan, Kansas, is guest editor of this issue of the Harvard Medical Alumni Bulletin.

Tales from the Trenches

by Richard J. Hannah

IT IS A DISTINCT HONOR TO PARTICIPATE on the same panel with Ned Cassem '66 and John Ludden '66. Each is an accomplished physician, psychiatrist and administrator.*

Ned, a priest-physician and chief of psychiatry at the Massachusetts General Hospital, is a role model for us general internists. Why do I say this? I say this because general internists can relate to the religious vows of our friend and colleague: relative poverty, relative chastity and absolute obedience.

The first vow need not be discussed. The second vow deserves an explanation. One can begin to understand the second vow of the general internist if one consults the wisdom of American humorist and philosopher Garrison Keillor. The general internist, like a French horn player in an orchestra, devotes so much time to his calling that there is little time for anything else. General internists (and French horn players) sometimes are required to be celibate—often by their wives!

And then there's the third vow—absolute obedience. In this day and age it is a very important vow for an internist, who must at all times be obedient to the PRO people and to the local utilization review compliance officer!

Our second panelist, psychiatrist John Ludden, is the medical director of the largest vertically integrated med-



Richard Hannah '66 is a general internist in private practice in Salem, Massachusetts. (Aesculapiad photo, 1966.)

ical insurance company in Massachusetts, the Harvard Community Health Plan—a company conceived by our alma mater and our dean in the 1960s and dedicated to the proposition that Harvard knows best! (Also it seems, at times, dedicated to the elimination of physicians like me.) Recently, several internists in the metropolitan area sought protection from our HCHP predators under the endangered species act!

In the mail to my house recently came a letter from Harvard Community Health Plan—in fact from John's marketing director. Note the snappy logo in the upper left corner. Also note the headline, which indicates that, at last, Harvard has brought "quality" health care to our North

Shore area! However, Jack, dare I make a suggestion to your direct mail person: the solicitation of my wife's affection for "The Plan For Life" reflects a slightly archaic mailing list, as it is addressed to her maiden name, although we had been married for eight years when she received this. Please instruct the direct mail department to move the listing of our medically deprived home from the Ws to the Hs.

I ran into Ted Jacobs '66 recently on his way out of the Massachusetts Eye and Ear Infirmary. I was with my brother and father waiting for the OR schedule to become disentangled so Dad could have his ocular surgery. Ted and I hadn't seen each other for 10 or 20 years. He asked me what I was doing with my life and with my Harvard medical education. "Solo practice," I said. "General internal medicine," I said. "In Massachusetts. . . at a community hospital outside of Boston," I added.

Ted looked at me with a mixture of alarm, pity and wonderment. There was an awkward pause. He then hesitantly asked, "Do you find any source of satisfaction in your daily work anymore?" When I said, "Yes," he showed even greater concern for my state of mind. I thought I saw him shaking his head slowly, then he changed the subject.

Ted's thoughtful probing deserves serious consideration. How could anyone but a Pollyanna be happy practic-

*This talk, originally entitled "Reflections of a (usually) Happy Internist," was given at a symposium presented by the 25th year reunion class, June 1991.

Does my satisfaction with my work show a curious mid-life euphoria disconnected from reality?

ing medicine today while corporate executives, insurance clerks and plaintiffs' attorneys seem to despoil the medical landscape? How could anyone but the most naive not bridle at the meddlesome busybodies peering into my patients' charts and over my shoulder? How could any doctor whose reticular activating system functions at all not resent the loss of esteem our profession seems to have suffered over the last 25 years?

Our profession in America in 1991 seems to be in very rough shape. We seem to have lost all sense of our professionalism. We seem encircled and set upon by our colleagues the nurses, sniped at by our "business partners" the hospital administrators, viciously attacked by our patients' attorneys, and frazzled by forms, memos, alerts and other inane pieces of paper. Many of my colleagues, alas, seem to think that the magical and warm doctor/patient relationship is now as archaic as the old basal metabolism rate.

So how can a general internist be happy? How can a person be in solo practice in this day and age? I have 50 years of living, 24 years of education and training, 21 years of medical practice (19 in private practice) softened my frontal lobes? Does my satisfaction with my work show a curious mid-life euphoria disconnected from reality?

I think not. I think that the doctor/patient relationship transcends all the travails of contemporary American medicine. I find that when a patient calls me or consults me in the office or hospital, I am privileged to participate in a unique role, one which

cannot be performed by anyone else. Each encounter is special; each interaction is unique. A patient (not a client, not a customer, not a unit of productivity) seeks medical advice. That person, and that person's friends and family, are expecting that my spirit and brain will be concentrated solely on him or her. That person will have, I hope, my undivided attention.

In the consultation room of the office, a place where an internist can have a great amount of control over the environment, it is (or should be) as

won't do very much good." I suppose, in a limited sense, there is some truth in that aphorism. In a limited sense. Maybe.

Some people wonder if a general internist isn't over-qualified for being a modern day GP. There is food for thought here. After all, we spent four years in college, four years in medical school, four years in training, and probably two years in the military or some equivalent endeavor before starting into our main work. And for what? To be a kind of second-string utility



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quiet and as focused as the operating room. It is one doctor and one patient. It is where a mini-drama of medical detective work unfolds many times each day. The whodunnit begins with the patient's narrative, with a few prods from the physician-sleuth. The scene then breaks to the exam room and soon, we hope, concludes with the triumphant "Aha!"—the diagnosis!

Better than the whodunnit, however, the final scene shows not a vicious murderer dragged off to jail in leg irons but, instead, the treatment. It is gratifying to see that the treatment often works!

Some of my surgical colleagues argue the old saw, "If it can't be helped by warm compresses or by cold steel, then you can go to an internist, but it

infielder? A referral service? A physician finder who gets the patient to the cardiologist, the surgeon, or some other action doctor who can take charge? Is an internist a jack-of-all-trades, master of none?

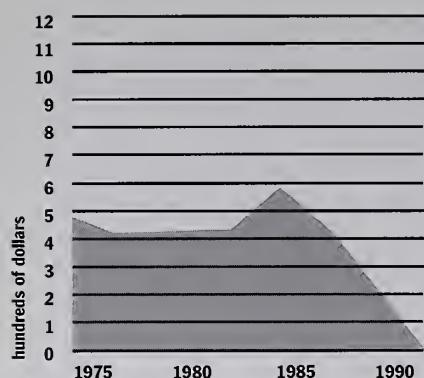
It turns out that that view is not held by our patients, nor by our specialist and sub-specialist friends! (Well, not by most of our colleagues. There is the occasional thoracic surgeon, often with the words Massachusetts General Hospital tattooed on his chest, who betrays his feelings about us.) Our patients and our colleagues want a thoughtful, caring, well-trained personal physician.

One aspect of my medical life that I particularly like is the sense of team play between myself and my colleagues

on behalf of our patients. This crucial collaboration is a joy to behold when it works well. I like and admire my colleagues. There is a fraternity forged from taking care of our patients, particularly very ill patients, which is very special. The application of different skills and technologies for making a diagnosis or effecting treatment is a team effort. In the same way that there is a reassuring power in being able to tap into wonderful pharmacology and dazzling technology, it is

An internist is a humanist, not a businessman.

medical doctor" for promotional activities. The graph illustrates several points: first, in 1972 it was considered ethical for a physician to run an announcement in the local paper and



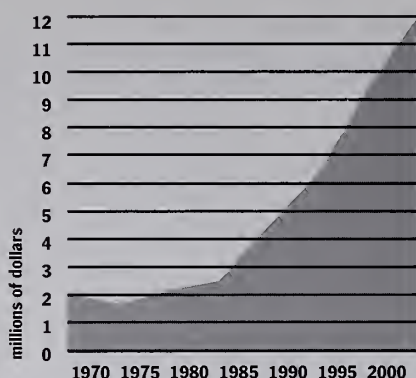
Dollars budgeted by a "local medical doctor" for promotional activities.

a great satisfaction to be able to call upon my friends in other medical disciplines for help. I like that.

One essential ingredient to happiness in a solo medical practice is having excellent, like-minded internists with whom to share medical responsibilities on nights, weekends and vacations. Happily, over the past 19 years I have been blessed in this regard.

One of the enjoyable aspects of our collaboration is the occasional breakfast meeting we have to work out schedules, comment about our hospital, medicine, the world and our role in it. Occasionally, we wonder about the role of advertising in a medical practice. We debate and muse. Finally one of us went back through old tax returns, office records and miscellaneous scraps of paper and prepared a chart.

The chart plots, from 1972 to present, the dollars budgeted by a "local



Marketing expenses for an "important HMO."

to mail announcement cards to the doctors in the area. (One might infer from this that all other promotional activities were considered unethical in 1972. One would be right!) Note the units on the Y axis: hundreds of dollars.

Secondly, the graph shows that the local medical doctor's promotional expense dropped for awhile and then gradually rose at about the rate of inflation. The blip in the early and mid-1980s reflects the zeal of the Yellow Pages salespeople, and anxiety about certain anagram entities (whose three-letter word was coined by futurist Paul Elwell) that were showing up in our area. In the 1980s those of us on Boston's North Shore actually sighted the HMO!

Lastly, the graph shows that the local medical doctor finally realized that the Yellow Pages people were charging extra for a single-line listing

in the telephone book for the adjacent community. When that was eliminated, the budget for promotional activities fell to zero—a very suitable number, it seems to me.

The next figure illustrates marketing expenses for an "important HMO." This graph illustrates several points: the Y axis is in millions of dollars (or possibly tens of millions—our researcher wasn't exactly sure which). Here, too, there's a blip in the early and mid-1980s, reflecting when Madison Avenue and corporate medicine found each other. And lastly, the line projected into the future has a very steep slope. It looks like the dollars taken from patients' paychecks and used for marketing, if projected out to the year 2001, equal the amount of money needed to balance the budget of the Commonwealth of Massachusetts!

In any case, the occasional meeting of our group of five internists is a chance for us to reflect on things other than the newest beta blocker or the medical call schedule.

So how can an internist be happy with all the stuff going on out there these days? By seeing patients. People are interesting, people are comical. Our patients teach us so much—about disease, human behavior, and about the community in which we live and work. That's the key: one doctor and one patient. A blend of science and art; a blend of psychology, business, ethics and biology.

An internist is a humanist, not a businessman. An internist is a personal physician, not a gatekeeper. An internist is a doctor, a member of the noblest of the learned professions, not a pawn of an insurance company. So this internist tries to focus on the age-old interaction between doctor and patient, and lets all the rest blur away into peripheral vision. ❧

Cowboys and Other Characters

by George S. Bascom

Narrative sketches...

SLIM PICKERING

One of my great regrets is that I cannot capture Slim Pickering for you. Slim died of kidney cancer, game to the end. His passing took with it a lot of things: values that are increasingly rare, humor of a unique kind, character, integrity, unflinching courage, unpretentiousness, along with a sense of personal worth that gave him dignity, against which his unending whimsicality played. All this wordiness somehow defames the wonderful man.

He was a Flint Hills cowboy, tall, slender, sun-browned. He looked natural in denims, scuffed boots and spurs. His hat was authentic, dirty with work and sweat. When he took it off, his forehead was pure white, his sandy hair plastered to a narrow skull. He had a big nose and prominent Adam's apple. He was droll and slow spoken. Nothing escaped his notice and little his humor.

During the Depression he supplemented his income by rodeoing. I expect he had some fun at it, too. Not just the riding and roping but the storytelling. Orville Burtis, no mean storyteller himself, said the most enjoyable hour in his life took place at noon along some barbed wire, listening to Dan Casement and Slim swap stories at the top of their form.

I took a medical history on Slim one time and asked him if he had ever suffered a serious injury. "Nope," he answered. Surprised, I pursued it a little, asking if he had ever broken a bone. "Oh, hell, yes," he agreed. "I've broke my collarbones, my shoulder, both wrists and some fingers, my pelvic bone, a leg and my ankles, but never nothing serious."

He invited my dad and my brother John into his house



George S. Bascom, '52, a surgeon in Manhattan, Kansas, is guest editor of this issue of the Harvard Medical Alumni Bulletin. (Aesculapiad photo, 1952.)

one noon to break their day of quail hunting. He was still a bachelor at the time and warned them, "It ain't any cleaner inside, but it's out of the wind." A dog had somehow gotten to the ham, but Slim was still demolishing it slice by slice. My brother said you could make out the silhouette in the grease at the bottom of Slim's frying pan. It was about an inch thick.

One Sunday afternoon we watched Orville Burtis and Slim work some horses and mules. Slim kept up a steady commentary, pertinent, funny and without meanness. A mule snubbed to his saddle horn got excited, reared and threw a foreleg over the saddle on which Slim perched. He looked at the mule calmly and said, "All right, if you want to get in the saddle so bad, I'll just get off." He dismounted without

hurry and pretty soon the mule did, too. Having a mule wave a hoof in his direction would have bothered a lesser man.

Slim was good natured, but he could stand up for himself. A trucker once tried to honk and bull his way through a herd of cattle Slim was driving. They tell me Slim tried to call him off before he started the cattle running. But the trucker ignored him and leaned on the horn. Finally Slim pulled a wire cutter out of his saddle bag and pitched it through the windshield. When he had his full attention, Slim offered to get down off his horse and have it out, but about then the truck driver pulled in his horns.

Slim's cancer insidiously invaded and destroyed his adrenal glands. It caused fainting and weakness which I thought was simply due to wasting from the advancing malignancy. It distresses me to know we might have helped this strong man keep his feet a little longer by replacing his adrenal hormones. I don't recall a word of complaint from

him as the end approached. He just kept to his bed, did the best he could, and without fuss left us. He made life around here more fun. I hope he has found good grass.



THE JOHNSON BOY

My dad was a remarkably kind and thoughtful man. His patients sensed his affection for them, appreciated it, and reciprocated. I suppose part of his feeling for them was simple gratitude for business in a man who grew up poor, part was doubtless ego—Lord, what doctor doesn't hear that siren song?—but a lot was simple affection. I heard a great many stories about his generosity (none from him) and nearly 20 years after his death still do hear stories for the first time about acts of kindness.

I relate this one as I remember hearing it from my brother. Time and imagination may have embellished and altered the facts. But as I recall it, around 1946 in the spring, my father operated on 17-year-old Charlie Johnson and found an unresectable cancer of the stomach. Charlie was black and about to be the first of his family to graduate from high school. He was very proud of it. They all were, and they looked forward to his graduation.

Black folks in Manhattan lived in the south part of town, and most still do for that matter. Even Joe Louis lived in the black neighborhood when he was stationed at Fort Riley during the war. That was where the Johnsons lived. I assumed, if I thought about it at all, that was where they wanted to live. Although Kansas came into the Union free in 1861, it narrowly missed admission as a slave state a couple of years earlier. That is to say, there was a strong pro-slavery element in the state (abetted by a lot of border-jumping Missourians). And even the Unionists had deeply segregationist and haughty views on race relations.

So prejudice and unfairness were imbedded in our culture. Some of the doctors in Manhattan would not treat black people. To see a dentist, they came in the back door. But my father and Dr. Schwartz treated all alike freely and without condescension. It was a fact widely recognized in the black community and appreciated.

But to get on with the story, the Johnsons lived in a little white frame house under a couple of big elms, down by the tracks.

My father was moved by the plight of this boy who was working so hard to improve his lot against the elements of racism, poverty and his tragic illness. Besides all that, I think they just liked one another, my father and Charles.

As graduation approached, the boy's health failed. He grew thin and weak, but he was determined to get his diploma. My father arranged to get him a new suit and also to drive him to graduation. I wonder why his folks didn't get in the car with him. Did they not want to go? Did they have another ride or prefer to walk? Or was Charles so frail and sick they agreed the doctor should attend him?

My father and my brother picked Charlie up that night. It was late May, raining and warm. Drops slanted through the headlights shining onto the front porch. My brother met Charlie at the door, and helped him to the car. They drove on the rain slicked streets to the high school where, with my brother's help, Charlie made his painful way to join the other graduates.

I don't know who spoke that night. I rather pity whoever it was. If he was aware of the situation, no eloquence could have matched that moment.

When at last his name was called, Charles Johnson rose from his place and walked slowly and unassisted to the dais. He took his diploma, shook hands, and passed off stage. About a week later he died.



VIOLENCE

Dr. Bob Heasty, now retired, is a kind and gentle obstetrician. When it became legal in Kansas, he agreed to do therapeutic abortions. For many years he had attended deliveries and managed both routine and frightening problems in obstetrics. He listened sympathetically to the women for whom he cared, and to some degree this set him apart from other obstetricians of his generation. It also left him supporting a disproportionate number of troubled and dependent women.

In response to the desperate plight of some with unexpected pregnancy, he began to do abortions. As part of my staff duties, I reviewed his charts from time to time. In them was all the grief and regret that love can visit on people: women (sometimes with other children) whose husbands had long been overseas; desperate high school girls; women already overwhelmed with large families; college women about to graduate; girls forced into intercourse. One spotted the occasional irresponsible woman, but the vast majority were in tragic situations making sorrowful choices and appreciating Dr. Heasty's respect and gentle, nonjudgmental manner.

So it was a shock to hear a doctor declare in a deliberately loud and carrying voice outside his operating room, "They're killing babies in there." The force of the remark was brutal. The hallway echoed with its ugliness.

Bob was forced into retirement by heart trouble. No one else came along to take his place, so now women go to Kansas City or Wichita. The issue is agonizing since unwanted pregnancy really has no good solution—no solution without suffering and pain. Not many now who elect to end a pregnancy will get the understanding offered here for a time by Bob.



NIGHT CALL

The phone rang deep in the night. It was the emergency room. A scalp laceration. A call to the emergency room is

never welcome. It always interrupts something: reading, playing catch, eating, watching a favorite television show, even making love. It is always imperative. If one tries to put it off, one feels guilty and also worries about being reported to the ER committee. A doctor of introspective bent can always examine his motives with interest. One influenced by Thomas A. Kempis can make spiritual use of such a call. I rose from my bed, roused out of a deep layer of sleep, and thought something about an opportunity to exercise my gift for patience.

I felt comfortably virtuous as I drove up Sunset Avenue to the hospital. I even took the trouble to remind myself, with God listening, that it wasn't such a great sacrifice. Sure, the patient was drunk and would doubtless not pay for suturing his laceration. Yet, how big a deal was that, compared, for instance, to the crucifixion?

I noticed a tall woman smoking just outside the door to the ER. She was dressed in a bright maroon, very short dress, wore long bangles from her ears, seemed hideously overdone with makeup, and had her hair swept up in an extravagantly bold coif. I think I remember something glittering in it.

My guess was that she was a prostitute. Remembering Mary Magdalene, I gave her my most compassionate smile, hoping it conveyed a gracious lack of prejudice and nonjudgmental kindness. There but for the grace of God....

I nodded. "Good evening," I said.

Her eyes slowly and insolently swept me from head to foot and back again. "Well," she said. "You took your damn sweet time, didn't you?"



POTATOES

"Doc," he said. "Do you like potatoes?" He was a tall, fair farmer in his sixties, member of a generation that appreciated doctors and used to pay them in barter. He was a man from a simpler time, a gentler and more civil community.

"Yes," I told him.

"Well then, I'll leave some in your car."

I was touched as the overalled figure walked out of my examining room and down the narrow, mahogany-panelled corridor to the receptionist's desk. I really hated to charge him for an office call.

When I finished the day, I went out to my car. Sure enough, a 50-pound sack of potatoes sat in my back seat. They were bakers, and a whole lot more than we had any easy place to store. I knew my wife would have mixed feelings about his generosity. Of course, she hadn't looked into his guileless blue eyes and listened to his simple language.

When I explained all this to my wife and unloaded the sack, I found a tag fastened to it. I took it to be a note of gratitude. But in the kitchen, under good light, I deciphered his rough hand: "For Dr. Bascom potatoes 50 lb. \$29.50. Delivered."



DRAGON BITE

Miss McIntyre was a tall, angular nurse in her mid-50s who had run the Neurosurgery Clinic longer than any of us interns or residents, transients through the system, could know. She was a fixture, a humorless senior nurse who had graduated from the frantic activity of floor nursing to the low key administrative routine of Dr. German's clinic. Her main job was getting the face sheet on the chart right for each patient: name, age, sex, marital status, address and chief complaint.

Dr. German was a wonderful doctor. He had trained with Harvey Cushing and though quiet and soft-spoken, was deferred to by everyone because of his skills in neurology and neurosurgery. He was Catholic and had migraine headaches, but he seemed a Norman Rockwell Yankee: lean, white-haired and spare of speech. As interns and residents, we examined the patients first and then presented them to Dr. German. It was a good way to learn neurology, but it was slow because he carefully repeated everything. His clinics always ended late, after six, which may have accounted for his migraines. It was a gentlemanly, decorous and highly professional clinic.

When Wyman Carroll came in, he took a seat at the desk near a door letting onto the corridor along which the examining rooms were arranged. There sat our presiding nurse like Cerberus, and she gathered the important data from this patient, who had an unusual air of vigor and health about him. I can still see his tan and his barely restrained enthusiasm and physicality when I think of him. A tan in mid-winter in New Haven was an occasion for comment in the 1950s. Come to think of it, so was barely restrained enthusiasm.

When she asked the nature of his problem, he answered, "A dragon bite." Miss McIntyre gave him her severest look. He returned it without embarrassment or apology. She sniffed her disapproval and refused to write it down. Instead she marched him off to an examining room and handed me the chart. "He's a strange one. He said he had a dragon bite." She shook her head and went back to her desk.

I went in with chart in hand and introduced myself. I grinned at him conspiratorially. "Miss McIntyre says you have a dragon bite."

"Yes," he said, by now accustomed to disbelief, "I do." Then the story came out from this lean, energetic Yale graduate. He was a collector of specimens for zoos whose work had taken him all over the world. The San Diego Zoo wanted a Komodo dragon: a giant monitor lizard, sometimes measuring ten feet in length and four feet at the shoulder. It is found only on the island of Komodo, 300 miles east of Bali in the Dutch East Indies. Free from natural predators, it feeds on deer, wild pigs and monkeys.

Wyman Carroll took the job, flew to the East Indies and sailed from Bali to Komodo on a native vessel. His crew spoke little English, but with their help he constructed

heavy wooden cages baited with decaying wild pig. Before long their efforts were rewarded. But Wyman was not entirely satisfied with the size of the first lizard they caught, so they let it go. Before long they trapped one of great size. It had fed on the carcass in the cage and was full of fight as Wyman and his crew prepared to truss it up for transport to the ship. When they had a rope around its neck and another around its hind quarters, they pulled it from the cage. It began to thrash wildly and they lost control. Wyman remembers being struck by the powerful tail, which knocked him to the ground at its head. His last recollection was of the gaping mouth plunging for him. He threw up his right arm in defense.

He came to on blood-soaked ground. The terrified crew had deserted him so he made his way to the beach, cradling his useless right forearm with its deep, dirty laceration—a semicircle of impressive size—that had divided his radial artery, ulnar nerve, and a portion of his median nerve, along with assorted tendons and ragged muscle bellies.

That was the end of the expedition. They sailed back toward civilization and in a week reached the first doctor, an Indian expelled from his native county for ineptitude. By then the forearm was terribly infected with exotic organisms. Antibiotics did little good. He was shipped to Singapore, where an English surgeon shook his head and told him nerve repair under the circumstances was impossible. He advised transfer to Australia where climate might discourage the infection flourishing in his soft tissues. And there the arm did heal.

The Australian neurosurgeon referred him back to Dr. German. I felt a surge of parochial pride that our chief's reputation reached that far. It made me feel enlarged, a familiar of the Indonesian isles, Singapore and Melbourne. Rudyard Kipling and Joseph Conrad whispered in my ear, sang rather, and, for a moment, the austere, unadorned corridors of New Haven Hospital wavered in tropical light. That was his history. The physical took less time. His hand was badly crippled, the scars clean and white in a muscular tanned forearm. Dr. German advised further observation and our patient walked out past an unforgiving Miss McIntyre. Before he left, I learned he had been scuba diving in the Caribbean during his recuperation and that his next project was a Siberian tiger. Then I went off the service and lost track of him.

I'll tell you what I think he did for me. He showed me it was possible. It? Yes, anything really. That I was trapped in a demanding, consuming surgical residency was only an illusion. There was, after all, Bali and the island of Komodo.

...and poetry

BEING THERE

Unhurried, easy in his chair, John H. Hennessey reflected without heat on changes in the way we practice medicine today. Hennessey said

"You expected to take care of people
in the old days. If they couldn't pay,
well, hell, you wrote it off. It was
understood...you charged what you thought
people could pay. I only gave
a bill to a bill collector once. He collected it
and then ran off with all the money."

Hennessey laughed. Across the table Homer Skinner grinned. He knew. He'd practiced surgery in Carroll for—

God, about a hundred years! In his forties
it came to him he'd never be a professor, write
important papers, or teach a dozen worried residents.

He felt pretty inconspicuous in Carroll.
But a Lutheran minister's son ruptured his spleen,
a sharp old doc down south of Carroll
called him in. Homer took out his spleen
and saved his life. Oh, he knew
any surgeon worth his salt could have
done it, too. But he was the one who was there,
And he, Homer Skinner, did it, no matter others
could have. That's the point.

They brought him a basket of orchids that Christmas. But the splenectomy that night was Homer's turning point. From then on he was satisfied to be the surgeon who was there. ❧

Neurology Far from the Madding Crowd

by Paul H. Altrocchi

Patria est,
ubicumque est
bene.

*Wherever we are
content, that is our
country.*

Marcus Pacuvius (220 - 130 B.C.)

Can someone exposed to the culture, grace, civility and charm of Cambridge and Boston be content in the high desert region of Central Oregon, which was described by an early immigrant as "a barren, God-forsaken country, fit for nothing but to receive the footprints of the Savage and his universal associate, the Coyote?"

The answer is "yes," but if one chooses a medical career in the beautiful rural region of Central Oregon, only if one's Bostonian origins are carefully suppressed! Harvardian background, it turns out, accrues no brownie points among local tree-fallers, mill-workers, ranch hands, Native Americans, antelope or coyotes.

With somewhat insistent indoctrination by prestigious medical schools about the importance of the pursuit of excellence, advancement of scientific



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knowledge, and the ennobling career of teaching, it would be difficult indeed to finish training at world-renowned academic centers and come forthwith to the small town of Bend, Oregon to launch a neurological practice. The transition is much easier, however, in mid-life, which is when I made such a move, after already having tasted the stimulations and frustrations of academic teaching, research and many years of neurological work in a large group practice in California.

Why Bend? Because not only is the level of medicine very high in Central Oregon, but also because Bend is far from the madding crowd, remote from California's hectic pace, and is tranquil, unspoiled and situated in truly lovely natural surroundings.

You will find something more in woods than in books. Trees and stones will teach you that which you can never learn from Masters.

St. Bernard (1091-1153 A.D.)

With a background of Switzerland-like snow-covered mountains and splendid coniferous forests, Central Oregon is one of the most beautiful and untouched areas in the United States. Add to that its significant underpopulation and Central Oregon is an absolutely magnificent place in which to live, especially if one is oriented towards nature and the outdoors.

There is outstanding downhill skiing 30 minutes from Bend in the spec-



tacular natural environment of Mt. Bachelor. Excellent cross-country skiing, with dramatic views, is available in many nearby locations. One can canoe on a beautiful mountain lake, usually alone, also within 30 minutes of Bend. No water-skiing is allowed on most Oregonian lakes, so they are peaceful and quiet. Excellent hiking opportunities are available everywhere, either in the nearby high desert, or walking in the woods, or climbing steep mountains or glaciers. Superb trout fishing and hunting are only a few minutes away. One can even learn to hunt elk with bow and arrow—a fourth-year elective I must have missed at HMS!

Fortunatus et ille
deos qui novit
agrestis.

*Fortunate also he
who is friends with
the rural gods.*

Aeneid, Virgil (70 - 19 B.C.)

Central Oregon was not always regarded as beautiful and peaceful. The first white explorers and surveyors, such as Peter Skene Ogden in 1826 and John Fremont and Kit Carson in 1843, encountered the expected wilderness hardships, including Indians, not all of whom were friendly. They therefore travelled through this region rather rapidly. So did the wagon train immigrants, many of whom were experienced farmers, and who began traversing Central Oregon in 1843. For the next 50 years they were negatively impressed by the infertile soil, arid climate and sub-optimal agricultural opportunities, and therefore kept moving westward to the



Cascade Mountains photo courtesy of the Bend Bulletin

fertile, wetter valleys beyond the Cascade Mountains towards the Pacific.

Although Central Oregon has been occupied by Indians for at least 14,000 years, the non-Indian settlement phase began in earnest during the Homestead Era between 1906 and 1916. This was when the federal government, looking at western maps of nonpopulated spaces, and not being cognizant of the poor soils and dry climate of this high desert region, encouraged homesteading by granting settlers 320 acres of land for \$10. Despite immensely hard work and fortitude, most settlers failed within a few years, offering often tragic testimony to the harsh environment of Central Oregon when water is not available.

The high hopes and optimism of homestead immigrants from the eastern United States often abruptly disappeared as they first encountered the vast panorama of desert, sagebrush and lava. Central Oregon historian Raymond Hatton mentions one such pioneer, who describes her mother's reaction:

"At the sight of it all, Mother burst into tears. My, how the tears flowed! We had travelled clear across the country. . . finally arriving at a flea-bitten hotel in a Wild Western town called Bend. Now this was to be our new home! Mom remembered back to her lovely home in Philadelphia—the maple-lined streets, the neat lawns, front and back, of the solidly built

house. She remembered her collection of fine china, glassware, and silverware we had sold for this God-forsaken land. And she cried some more."

At a time when Boston was already an elegant and historic city, prominent on the international scene, Bend wasn't formally planned and organized until 1904. By 1911, despite its scenic location along the banks of the sparkling Deschutes River, Bend was still only a small, dusty western frontier town. Urling Coe, Bend's first physician, described the town as "hurry and bustle on all sides along with the tang of romance and excitement in the air. Freighters, stockmen, buckaroos, sheepherders, timber cruisers, gamblers, and transients of all kinds who

had been attracted to the town by the boom, thronged to the bars or played the gambling games, and the stores were doing a rushing business. There were eight saloons with open gambling and a lusty red-light district consisting of several small shacks on the riverbank in the lower end of town."

Although Harvardians in Central Oregon are almost as rare as a Nez Percé Native American in Boston, a few such "lost souls" have wandered in and even made an impact! The first Harvardian on the Bend scene was George Palmer Putnam, scion of the prominent eastern publishing Putnam family, who later became a well known writer, entrepreneur, and also the husband of Amelia Earhardt. He was the first owner of the *Bend Bulletin*, publishing it from 1910 to 1917 and transforming it into one of the West's best small town newspapers, which it remains today. He sold it to Robert Sawyer, a young Harvard Law School graduate, who published the *Bulletin* for the next 40 years.

The first New Haven influence in Central Oregon arrived in the form of Tom Shevlin, captain of the Yale football team, in 1905. He established the first large lumber mill in Bend, which went into production in 1916 and, along with the Brooks-Scanlon Mill, formed the main economic base of Bend into the modern era. Although Beaver Coaches, Fuqua Homes, and a few other manufacturing industries have come here since, Bend is still basically a logging, milling, wood-based community with fewer than 25,000 residents.

So, after nine years at Harvard, neurology residency at Columbia-Presbyterian Hospital in New York, research training at NIH, full-time faculty at Stanford, and fifteen years as chairman of the Department of Neurology at the Palo Alto Medical Clinic, a 160-physician group practice, what are the two vital sine qua nons that an immigrant neurologist must instantaneously do upon arrival in Bend? First is to immediately remove

one's California license plates and switch them to Oregon plates in order never to be identified as the epitome of the intrusive alien, namely a Californian; and secondly, to learn promptly how to pronounce correctly the word "ORegun," with emphasis on the first syllable, not "oreGON," which forever labels one as an unwanted foreign invader into the pristine domain of this virginal territory!

It is also best to maintain a low profile as a neurologist and not experiment with catchy personal license plates such as "NEURONE" or "SYNAPSE." One naive attorney came to Bend with a license plate stating "YALE." He still can't understand why his practice built so slowly! Since there is a strong contingent of Stanford professionals in Bend, and since Stanford is a respected western institution, one can hint at a prior Stanford affiliation without threat of immediate tar-and-feathering. Stanford, like the Vatican, is regarded as a separate and independent entity, having no connection whatsoever with that evil, aggressive, rapacious neighboring state of California!

For historical reasons, certain small towns and cities in the United States have levels of medicine much higher than would be expected by their num-

ber of inhabitants. Bend falls into that category. The family physicians are the finest I have ever encountered. All essential medical and surgical specialties are well represented, including the latest techniques and scientific devices, and half of the specialists here could be, or have been, full professors at medical schools. The weekly grand rounds at St. Charles Medical Center in Bend would be a credit to any academic institution, with 60 percent of the presentations by local physicians and 40 percent by full-time faculty members from all of the West Coast's medical schools, including UCLA, Stanford, UC/San Francisco, Oregon and Washington.

Most of St. Charles Medical Center's 175 hospital rooms are singles with beautiful views. This, in combination with caring nurses, has led me to the interesting conclusion that patients get well two days faster per week than in all the large-city, double-roomed, more hectic hospitals I have encountered. The difference has nothing to do with the medical care rendered by physicians. As Norman Cousins repeatedly pointed out, for instance in *Anatomy of an Illness*, MDs often forget the importance of nonmedical influences on the healing process.



Photo courtesy of Raymond R. Hatton, Central Oregon Community College.

Large city cultures inevitably tend to propagandize that small towns manifest lesser values, less meaningful lifestyles, and generally lesser amounts of all the good and valuable things in life than big cities. It was a very pleasant surprise, therefore, never having been exposed to small towns before, to learn that this turns out not to be the case! The amount of talent, intellect, diverse interests, creativity and zest for living is a constant source of delight in a small town. I have lived all over the United States and Bend is the only one of these communities where physicians virtually never talk about medicine on social occasions.

One is perhaps more motivated in small towns than in large cities to become a "joiner," e.g., to become a member of the Audubon Club, the Astronomy Society, the Native Plant Society, the local theatre company, the Oregon Natural Desert Association. When I became president of the Bend Rotary Club, I had the opportunity to travel in the beautiful Russian winter to help establish the first Rotary Club in the Soviet Union, namely in Irkutsk, Siberia, a university town of 250,000 inhabitants and the sister city of Eugene, Oregon.

For neurologists used to seeing the most difficult diagnostic problems within a population base of 10 million, the biggest drawback of small-town solo practice is the fewer number of what delights the neurological mind, namely complex cases and "tricky" diagnostic problems. Inevitably, the emphasis must shift, and one learns to derive greater enjoyment from interaction with different subcultures and the intricacies and even hazards of their unusual occupations and lifestyles.

For example, serious head injuries, even causing death, may result from being kicked by a llama, being struck by a rapidly-turning horse's head, from being buried by falling bales of hay, from accidentally slipping down a cattle chute and being trampled by frightened animals about to be slaughtered,

or by being driven into a fence post by an unhappy pig!

One young couple in their late teens described the long hours and difficult tasks involved in growing earthworms commercially. Because earthworms seemingly would only have value as inexpensive fishing bait, all neurological bills were forgiven for these struggling youngsters until it turned out that they were grossing more than a quarter of a million dollars a year from their acres of exquisitely-fine worm fertilizer. Deemed matchless by agri-

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cultural buyers, the fertilizer was processed by tens of thousands of worms and brought a very high profit.

Strangely and perhaps inexcusably, Harvard College's curriculum does not teach much about worm fertilizer, the distilling of mint leaves to make peppermint oil, the fascinations of animal and plant farming, the processing of horse meat into "filet mignon" for fine restaurants in France, breaking wild mustangs, building log cabins, the latest gold prospecting techniques, or the complexities of transforming a tree into various types of high-grade lumber and timber products.

One of my first patients described his occupation as that of "ferrier." Despite training in Latin in the pristine halls of East Coast educational institutions, I was forced to ask him what that meant. Although he was a seventh

grade drop-out, he responded: "I guess you don't know your Latin!" He then proceeded to tell me that the word "ferrier" came from the Latin "fer," meaning iron (which immediately embarrassed me because I was very familiar with that word) and that he was a horse-shoer.

I then asked him whether he was a good ferrier. He responded that both his father and grandfather had been ferrriers, and they had taught him from the earliest age the beauties and intricacies of horses' hooves. He went on to describe how he carefully palpated each hoof's hardness and texture, observed the infinite variety of each hoof's granularity and patterns, its shape, size and individual characteristics. He would then locate or make precisely the right horseshoe to fit that hoof alone, making the shoe a perfect continuity for the elegant limb of the horse. He was only 29 years old and spoke of his craft with the enthusiastic eloquence and expertise of a Michelangelo.

I saw one 17-year-old lad for muscular headaches. He had been married for two years to a pretty 16-year-old country girl, and they had a 9-month-old daughter. He was already weighed down by his financial and domestic responsibilities and had headaches, epigastric distress and insomnia. Since theirs had clearly not been a "shotgun" marriage, I asked them how they happened to get married so young.

The boy answered: "We are from Prineville." I stated that I knew they were from Prineville, and I asked him again why they married so young? Again he answered: "Because we are from Prineville!" I asked him to explain this to me since I was new in town. He stated that in Prineville, by the 10th grade, there were only two things to do, either go bowling or get married. He and his girlfriend, and most of their classmates, didn't like bowling, so they all got married!

One very early humility-reminder for me, the enthusiastic new rural neurology practitioner, was emphasized by a local rancher who came in with a very

unusual neuromuscular disease, a special interest of mine since NIH and Stanford. No definite diagnosis had been applied to him after several years of searching, despite being seen by a number of specialists.

After examining him, I was convinced that he had a rare variant of spinocerebellar degenerative disease. At the end of the initial consultation, I confidently reassured him that we had a few tests to do but that I was quite certain that finally his mysterious ailment would be diagnosed correctly! Without hesitation, and without any indication that he was even minimally impressed, he responded: "So who needs a diagnosis? I want some treatment!" Perhaps this was the perfect rebuff for the overly analytical, diagnosis-oriented neurologist.

What one could call the Central Oregon "macho spirit" is actually an enviable leftover from the American pioneer spirit. The typical Central Oregon worker is either a high school graduate or drop-out who marries his high school sweetheart at age 18 and starts very hard manual labor as a mill-worker. He maneuvers up to 30 tons of wood a day through the mill, cuts all his own firewood, hunts deer, fishes, goes camping, often builds his own home, sometimes even a log cabin, in the true frontier tradition. Spartan and somewhat red-necked, totally individualistic, self-reliant and fiercely independent, he is very loyal to state and country, but woe to the politician who tries to inhibit his individuality and self-determined lifestyle!

When a physician here prescribes "absolute bedrest," one must realize that this may mean that the patient is still working half time at the mill and cutting one or two cords of wood a day from the forest. Therefore, in Central Oregon, "conservative treatment" may have more than one cultural interpretation.

Because of the relative inhospitality of Central Oregon's desert atmosphere and the resulting delay in its development, Oregon is a half-century closer

to its history than other western states. Whereas California's homestead houses and Native American relics have largely disappeared, Central Oregon's more difficult climate and harsher terrain have led to the preservation of fascinating historical evidence of its early history. Old homestead remnants abound, immigrant trails still survive almost untouched across the desert, and a short hike into the desert or foothills frequently yields well-preserved Indian relics, such as beautifully-crafted arrowheads, spearpoints and petroglyphs on canyon walls. Recently, remarkably preserved sagebrush-rope sandals dating back more than 9,000 years were uncovered in a cave.

Here, "absolute bedrest," may mean that the patient is still working half time at the mill and cutting one or two cords of wood a day.

Surrounded by natural beauty, it is easy to understand the importance to Native American cultures of living in harmony with nature, and their appreciation for even the most subtle manifestations of nature's handiwork. Crowfoot, an Indian orator, expressed his feeling for nature and the brevity of life in 1890 in his last words: "What is Life? It is the flash of a firefly in the night. It is the breath of a buffalo in the wintertime. It is the little shadow which runs across the grass and loses itself in the sunset."

It is a great pleasure, as a former anthropology major from Harvard, to

take care of Native Americans, including those with names like Stormy Thundercloud. One day, a Warm Springs Indian mother brought her lovely five-year-old daughter, Aerie, for an evaluation of seizures. By coincidence, I had just finished reading all of Shakespeare's plays and several Shakespeare commentaries. I asked the mother where she got the name "Aerie." The mother, who never finished junior high school, immediately responded: "You must not know your Shakespeare! 'Aerie' means eagle's nest, and I thought it would be a nice name for an Indian girl." I was somewhat at a loss for words, but told her it was a wonderful name for a beautiful daughter.

It puzzled me how she could possibly have encountered that unusual name. When she showed up for a follow-up evaluation two years later, I immediately asked the mother how she had happened to find the name "Aerie." She promptly answered: "Oh, I have never read Shakespeare in my life, but a few days before I delivered her, I was watching a quiz program and that name stumped everybody, and they said it came from Shakespeare! I loved the meaning, 'eagle's nest', since it fits so well with our Warm Springs Indian culture, and so I named her 'Aerie'!"

Just as tribal groups and native people in underdeveloped lands have over the centuries found medicinal wisdom in plants and plant products in their constant struggle against life's hazards and diseases, (eloquently described by Richard Evans Schultes in the Summer 1991 *Harvard Medical Alumni Bulletin*), so modern individual practitioners of medicine, in their daily contacts with patients and diseases, accumulate a vast sum of experiential wisdom. This reservoir of knowledge is too often untapped and under-utilized, because it has never undergone the rigid Cartesian protocol of well-controlled, double-blind studies. Therefore it tends to be neglected and often looked down upon by the rigidity of modern

science, which demands "scientific proof" for any idea or approach that conflicts with the reigning dogma. Physicians should remind themselves that a significant proportion of our "modern scientific medicine" has never been proven and yet we demand "absolute proof" of any new theory or idea that is suggested as a replacement for our current belief system.

I would not agree with those who feel that private practitioners, either those who practice Western or non-Western medicine, do not discover, and have not discovered, much in the way of valuable scientific knowledge. In the field of neurology, for example, I am aware of several major diseases that are still taught at most medical schools as being "untreatable," or only partially treatable, which are actually eminently treatable, and knowledge has been available suggesting their treatability since 1965.

The lessons of cardiac transplantation immunology convincingly showed in the middle 1960s at Stanford that "conventional doses" of immunosuppressant drugs were often quite inadequate in the treatment of transplantation rejection, and that higher doses allowed such patients to survive. Transfer of the same knowledge to immunological disease in neurology—such as multiple sclerosis, Guillain-Barré disease, acute transverse myelopathy, recurrent brachial plexopathy—immediately brought those supposedly untreatable diseases into very treatable categories.

For example: relapses of multiple sclerosis can not only be treated successfully with high doses of immunosuppressants, but can actually be prevented in most cases by regular, periodic, preventive treatment, a conclusion based upon 25 years of experience. High dosage, intravenous Solu-Medrol can dramatically and almost immediately halt the progression of Guillain-Barré disease in most cases; the average in-patient stay in Bend for Guillain-Barré disease is eight days, compared to an average of over

two months at many large teaching hospitals.

Other practicing neurologists have noted similar results for many years, but the lack of controlled studies has led to vehement rejection of these approaches despite ample scientific logic for these treatment concepts. Unfortunately, the rigidity of the Western scientific approach, which demands absolute proof and total rejection of the unproven, is sadly adverse to patients afflicted with such disorders and can prevent the acceptance of effective treatment regimens for an entire generation.

As Max Planck stated in his *Scientific Autobiography* and as many eminent scientists—such as Thomas S. Kuhn, Carl Popper, Linus Pauling, Imre Lakatos, Bernard Lown and Stephen Toulmin—have subsequently agreed: "A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die and a new generation grows up that is familiar with it." Planck also said: "Science advances funeral by funeral."

E.G. Boring put it this way: "Important theories, marked for death by the discovery of contradictory evidence, seldom die before their authors."



Photo courtesy of Raymond R. Haffon, Central Oregon Community College

Norman Geschwind '51, the late professor of neurology at Harvard, commented in a 1984 article in *The Encyclopedia of Medical Ignorance* that "there is a widely held supposition that one's scientific peers are honest, well-informed, not swayed by prejudices, and open to imaginative ventures into the unknown." He also stated, "It is my purpose here to point out that in the field of the neurology of behavior, major advances were neglected, not for a few years but for nearly half a century."

Practicing physicians, not so tightly bound by protocol guidelines and the ideological necessity for "scientific proof" required by academic centers, and facing daily and personally the unfolding tragedies of the "untreatables," often are in a perfect position to discard outmoded concepts and initiate "unproven" but very effective treatment innovations. It is very difficult, however, to achieve adequate controlled studies in solo private practice.

We often forget, as Lewis Thomas '37 has elegantly and repeatedly pointed out, that "the principle discoveries in this century, taking all in all, are the glimpses of the depths of our ignorance about Nature." He also has appropriately suggested that perhaps we should spend more time emphasizing

ing to medical students and young physicians the frequent necessity for alterations in existing theories, and what is not known about science, rather than all that we seem to know at a given moment.

As Thomas has also said in his "Late Night Thoughts on Listening to Mahler's Ninth Symphony": "We have been teaching Science as though its facts were somehow superior to the facts of all other scholarly disciplines, more fundamental, more solid, less subject to subjectivism, immutable."

We often forget that for several million years of our own evolution prior to the early 1600s—when the Western medical analytical-deductive methods of science were introduced by Descartes, Bacon, Newton and others, and which modern scientists follow with cult-like adoration and devotion to the absolute exclusion of all other conceptual approaches—that all wisdom is experiential and scientifically unproven, including the evolution of millions of forms of animal and plant life, development of the great ancient cultures, the beauty of the Seven Ancient Wonders of the World, architecture, music, sculpture, art, drama, literature, Biblical wisdom, etc. Do we as modern scientists scorn and reject all knowledge, creativity and the incredible beauties and intricacies of nature because they are not the product of well-controlled, double-blind experimentation? Is it within the realm of possibility that we, the "scientists," are at times the ones who may be "double-blind?"

Do we so easily forget that native medical practitioners in India and Sri Lanka have had excellent anti-hypertensive medications and hypoglycemic agents for hundreds and probably thousands of years, or that for hundreds of years the "primitive" cultures of New Guinea have had contraceptive teas that last more than a week? Vast numbers of plant and animal products, with powerful pharmacological effects on many diseases and afflictions of the human body, have been discovered by

essentially all cultures, large and small, of every degree of complexity of "civilization," throughout history.

Experiential wisdom, both Western and non-Western, still represents an immense reservoir of practical medical knowledge waiting to be tapped in greater depth, deciphered and appropriately utilized. As Hamlet says: "There are more things in Heaven and Earth, Horatio, Than are dreamt of in your philosophy."

During a medical career, most HMSers, whether academicians or practitioners, diversify their medical talents, skills and opportunities, and do not remain unidimensional. In my own case, although the practice of rural medicine offers many highs and satisfactions, I know of no more stimulating medical diversity than taking the cue from a Sheldon Travelling Fellowship in tropical medicine from Harvard Medical School to the South Pacific and Africa, including Lambaréné, and subsequently making tropical medicine and tropical neurology an integral part of my career, primarily as a "hobby."

I have spent vacations and sabbaticals working in Central and South America, Okinawa, Sri Lanka, the South Pacific, Saudi Arabia, Africa and even our own fascinating Navajo Reservation, which have resulted in deeply felt and long-lasting "endorphin highs." Guild cards such as an MPH from Berkeley and a diploma in tropical medicine from the excellent School of Tropical Medicine in São Paulo, Brazil, are helpful but certainly not necessary. Any medical skill is greatly appreciated and needed in the beautiful countries of the underdeveloped world. Opportunities for medical work in the tropics abound, even for brief periods of time, and are highly recommended to one and all.

A fascinating tapestry of life awaits us all, and each of us must decide how best to weave and creatively integrate the greatest meaning, contribution, value and happiness for ourselves, our families, our professional constituency

and our friends. The combination of medical practice in a small rural community, with intermittent stimulating and captivating vignettes of practice in the tropics, offers rich opportunities for Harvardian pursuit of excellence.

As I sit on my deck on a high lava bluff in Central Oregon toward the end of a medical career, I can reflect on life while enjoying the magical natural beauty of snow-capped volcanic mountains against the sunset. I listen to a soft wind rustling through 120 acres of surrounding pine forests, interrupted not by sounds of civilization, but only by the occasional honking of geese in flight or the hauntingly appealing wildness of distant yelping coyotes, and I am reminded of another quotation from Virgil's Aeneid:

Rura mihi et rigui
placeant in vallibus
amnes, flumina
amem silvasque
inglorius.

*Then let the country
charm me, the
rivers that contour
its valleys. Then
may I love its forests
and streams, and let
fame and glory go by
the wayside.*

Doctor Quixote

by Michael T. Myers

IN THE WINTER 1989 ISSUE OF THE *Harvard Medical Alumni Bulletin*, I wrote a commentary extolling the virtues of solo medical practice in an inner-city Boston community. The following winter I closed my medical practice and am now fully employed as an internist with the Massachusetts Institute of Technology's Medical Department in Cambridge. What happened in the ensuing 12 months is as much a story about the reality of medical practice today as it is about my own personal evolution as a physician.

In the summer of 1984 I worked as a research assistant in John Parrish's dermatology laboratory at Massachusetts General Hospital. I had done well in my dermatology clerkship and I generally enjoyed the pathology of skin diseases. I naturally thought these to be sufficient reasons to become a clinical dermatologist. My research experience that summer and subsequent exposure to clinical dermatology, however, altered my opinion. On my last day of work, Parrish called me into his office to explore with me my career interests. He will probably never know what a pivotal role he had in shaping the course of my life.

Parrish asked me some probing questions about my reasons for coming to Harvard Medical School, and about what kind of physician I saw myself becoming. Naturally, desiring a residency slot in the MGH dermatology program, I dutifully answered that I greatly desired the life of a dermatologist, exploring the intricacies of skin diseases, or some such, but I was painfully aware all along that my answers sounded empty and vacuous. This wasn't "me" speaking these



Michael T. Myers '85 is an internist in the Medical Department at MIT. (Aesculapiad photo, 1985.)

words, but some image of myself I had constructed, in a life I hoped to create.

I remember riding my bicycle home from the lab that evening to our apartment in Somerville (I had just married about five months before), riddled with self-doubt and confusion. Why had I really come to medical school? What was I planning to do with this incredible medical education I had received? It was then that I knew some sort of career in primary care medicine was what I was destined for.

I enjoyed my three-month medicine clerkship at the Brigham and Women's Hospital, but was frankly scared off by the lifestyles of these internists—men and women who rarely left the hospital before 8:00 or 9:00 at night, looking dragged out and burdened by the very work that gave them so much excitement. I was scared away from the life of an academic internist into the realm of a more "lifestyle-friendly" profession, dermatology. This was important

to me as I had just married, and I desired a stable family life with children.

But, I truly enjoyed internal medicine: being on the trail of a "good" case (which is almost never good for the patient who has it), exploring a variety of diagnostic possibilities with lab tests, x-rays and the like, the real stimulation of morning report or work rounds, seeing patients' appreciative faces when they are being discharged from the hospital, being seen as the patient's doctor. These were the images I had when I first thought about medicine in my early adolescence. These were the most provocative images stirred up within me as I rode my bicycle home that evening. I decided at that moment to reverse the engines carrying me into dermatology nirvana, and to set my sights on primary care internal medicine.

I was fortunate to match at Mount Auburn Hospital in Cambridge, a wonderful hospital with truly wonderful attending physicians. Ronald Arky was almost a surrogate father to me and remains an important mentor in my life. Like all good HMS grads, I despised certain aspects of my residency: the lack of control over my life, the sheer fatigue and exhaustion, the endless political battles over the most ridiculous issues, etc., but I worked with people who were truly inspirational: fellow residents Stephen Boswell, Bruce Kramer, Virginia Palazzo, Catherine Mintzer; senior residents Mark Pettus, Bob Kitchell, Liz Zentz; and attendings Mary Wilson, Bill Kettyle '71, Charlie Hatem '66 and Bob Schiffman.

Midway through my second post-



Dorchester's Ashmont T station. Photo by Stuart Darsch.

graduate year I started thinking about the end of residency and the “next step.” I had seen a number of residents before me enter fellowships, other residencies, or take positions at Harvard Community Health Plan (the Plan as we called it), with not so much enthusiasm as resignation. It was as if people weren’t quite sure what to do, and so either continued the gestational period of residency or signed up for the Plan.

This was distressing, and I decided to make up my mind early about where I would practice and what I would do. Another residency, or even a fellowship, was out of the question for purely economic reasons. My wife and I had just had a wonderful baby boy, were still living in that same apartment in

Somerville, and couldn’t afford the “luxury” of being underpaid for my valuable medical services. Boston HMOs were top-heavy with MBA administrators, whose bottom line was the bottom line, and I did not relish the idea of being supervised as to the number of laboratory tests I’d order or having my patient encounters timed for efficiency.

Solo private practice in an underserved Boston community began to loom larger as an attractive possibility. Helping working-class people who were poorly served by the medical establishment was, I felt, my *raison d’être* for medical school in the first place, as I realized during that fateful summer day in 1984. I was filled with egalitarian notions of helping to save

the world (and making it safe for democracy). I became the embodiment of my medical school application essay, spewing forth all sorts of wonderful reasons why doctors had to do this very thing—take their services to the streets so to speak.

My mentors were skeptical; the consultant who worked with me on my business plan was even hesitant. But it’s hard to derail someone from good and benevolent works when he is in the saviour mode, which I was definitely in. So, convincing the now defunct bankers at First American in Dorchester of my superhuman abilities, I borrowed \$160,000 and opened a first-rate solo medical practice in Dorchester, Massachusetts on 8/8/88.



(There was something fatalistic about that date; Princess Beatrice, Fergie's first offspring, was born then—a confirmation of sorts?)

I greeted private practice with the naïveté and energy of a new battle recruit—long on training and idealism (“the cause”), short on pragmatism and practical sense. On my first day in practice, I fired my secretary, one of the hardest things I’ve ever done, because she was completely overwhelmed by work in the front office. I had hired her out of a great job at Mount Auburn, which she left amidst great fanfare to join that spitfire young physician Dr. Myers, who was not only going to change the world, but health care reimbursement and diagnostic

I became the embodiment of my medical school application essay.

coding! She worked for me at home until we moved into our newly furnished and renovated offices in July 1988. It was then that I began to see what would one day cause me to say, with tear-filled eyes, we’ve got to part (I couldn’t bring myself to say the word “fired,” it seemed so mean-spirited).

My mother came from Kansas City to help with the baby, be my medical secretary, and serve as “chief cheerleader.” It was then I learned why my medical practice courses always warned against hiring relatives—how can you fire your own mother? I occasionally found her dispensing medical advice and homespun quips to my patients over the phone, and I had to rein her in diplomatically with the gentle reminder that I was the “Dr. Myers” the public was calling.

She had some great marketing ideas though, like the time we printed purple handbills and took some of my business cards (with the printed logo I had agonized over for weeks) and passed them out to returning commuters at the

Ashmont T station not far from where my office was located. It was a great idea, and about 25 patients came to my office from that one. Five months later she returned to Kansas City.

Marketing—now there's a word I'm glad is part of some dusty vernacular in the deep recesses of my cerebral cortex. Nineteen eighty-nine was my year of "marketing," which simply means convincing a community where there are a handful of private docs that they should come see this wonderful-bright-board-certified-Harvard graduate, with a well-upholstered office, great prints and excellent bedside manner! One might say I was a natural at this aspect of my business, and the folks at Carney Hospital, where I had primary admitting privileges, nominated me for the American Hospital Association's "Physician Marketer of the Year" (now there's a dubious distinction).

I had the good fortune of finding a superb new office manager, Mary Connolly, who was a crackerjack at billing and coding, and handling every other aspect of my life in the office, including transcription from micro-tapes (which got me home at dinner time and saved my marriage). I remember the sheer agony of waiting for the postman to arrive with the day's mail, and the subsequent disappointment greeted by the \$8.76 checks (a fraction of my total bill) from Medicaid, Medicare, Tufts Health Plan, Blue Cross/Blue Shield, or any other of the 257 "health" insurers with whom I did "business." I learned an important lesson in 1989—health insurers are not in the business of paying claims of their clients (my patients), but are in the business of buying larger pieces of real estate in Cambridge, or investing in stock funds. Whatever these health insurance companies are doing, they certainly were not trying to pay my bills.

Here's the typical scenario. Patient Mr. X came to my office for a check-up. He was 57, a chain smoker, and had an LDL-cholesterol of 173. This man was a time bomb waiting to go off, and

I spent a good hour with him exploring his history, doing a complete examination, getting an EKG, drawing his bloods, counseling him about smoking cessation and the virtues of fat-free nutrition, and setting up his stress test at the hospital. My fee for this comprehensive tune-up was \$115.

I had an ace computer software program, which I used to submit the appropriate codes and billing information to his insurance company, and then I waited. And waited. And waited.

*Whatever these
health insurance
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they certainly were
not trying to pay my
bills.*

Three months later, a check arrived for Mr. X's visit that day—\$18.56. My office manager noted this payment, resubmitted the bill, and I waited again. And waited. And waited. Another check arrived for \$27.02, with the explanatory note that this constituted full payment for services rendered Mr. X: \$45.58.

This is actually not bad considering that some insurance companies pay far less for the same wonderfully comprehensive care. But that \$115 was not a charge I dreamed up; it was based on my office manager's salary, lease, debt service to the bank, and (God forbid) my salary, among other things. But that's it, bud, \$45.58, and all the rest, \$69.42, is written off as "lost revenue" because the Commonwealth of Massachusetts does not allow "balance billing," that is, recovery from patients of the difference between what their insurance company has reimbursed you

and the actual charge for the service. So you take the \$45.58, charge off the rest as lost revenue, and hope against hope that you'll be able to make up the difference by seeing more patients.

Here is the slippery slope down which good-natured, honest, primary care types like myself get into trouble—the notion that seeing more patients is the answer. You do see many "successful" internists practicing this carnival-like form of medicine: seeing multiple patients at incredible rates, doing multiple nursing home visits, working ERs for hospital admissions, and keeping people in the hospital for days. Why? They're trying to make up in volume what is written off month after month in lost revenue.

So then what happens? What happens is you take the little amount of money that does come in and pay your bills the best you know how. This means making choices between staff salaries and withholding taxes, between keeping your phone on and keeping the lights on, and frequently means not paying yourself because there is simply not enough money to go around.

At one point I decided to give myself a nominal salary of \$18,000 a year, but this was woefully inadequate to meet my mounting debts. So I started to moonlight.

I worked for more than a year at a zoo of an emergency room at Carney Hospital. This had two advantages: immediate income and referrals for my practice. At one point I was working two or three shifts per week in the ER, from either 6:00 PM to midnight, or 7:00 PM to 1:00 AM. Occasionally I was desperate enough to work the 12-hour overnight shift, 7:00 PM to 7:00 AM, but I did this only on Fridays.

I was mentally and physically exhausted, and broke. One day I had one of the ER nurses take my blood pressure and it was 134/94. I had never had any chronic illness, nor had any member of my family. It was then that I decided to quit ER moonlighting and find something less insane to do.

Carney Hospital, like other com-

munity hospitals, had had some trouble that year filling its residency slots, and thus created an "uncovered" medical service covered by daytime moonlighters who acted as "interns-for-a-day." The pay wasn't bad, and the work fairly innocuous. I signed up for a four-month hitch, a return to the days of beeper madness and endless questions from nurses and family members.

My pride had taken a severe beating by this time. Here I was, an attending physician, a Harvard great, reduced to the ashes of inserting Foley catheters and disimpacting elderly nursing home residents once again.

One day I had multiple admissions in the ER, was running all over the hospital trying to get things straight, and had inadvertently forgotten to bring up admission orders on an older gentleman with pneumonia, whom I had already started on IV antibiotics in the ER. I was greeted on his floor by an irreverent, irate, high school-aged unit clerk, who curtly spit out, "So, what took you so long in the emergency room?"

State laws, parental responsibilities, and my state of impoverishment prevented me from my first inclinations, so I calmly threw down the orders and retreated to my call-room. That was definitely the last straw. I knew I was a doormat for abuse, but I had some pride left.

As it happened, the Mattapan Community Health Center was looking for an interim medical director two mornings a week. Again, the pay wasn't bad, and the position would give me some authority, a chance to replenish my manhood and pick my chin up off the floor. I signed up, this time for only a three-month tour of duty.

The position at Mattapan coincided with the realization I had one day on a long walk to the bank that my days in private practice were over. The divorce was imminent, there was definitely no love left in this marriage between my practice and the state in which I had chosen to establish it. By this time, November 1990, I had over 2,000

patients in my practice and was able to give myself a raise to \$27,000. But the bills were just as hard as ever to pay, my bank had collapsed, my loans were in the hands of the FDIC, and the IRS had taken multiple sweeps through my business accounts for old withholding taxes. I was exhausted, frustrated and fed up.

I was again fortunate to be able to successfully acquire a position with the MIT Medical Department, where I have worked since March 1991. This is a truly wonderful place to work, and

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when I first came on board I felt like the Hungarian woman in those old GE commercials; you know, when the Berlin Wall comes down and GE is going over to help light up their lights: "I feel young again!"

And what about private practice? You can have it. There are so many problems right now with the reimbursement of primary care specialists—billing codes, diagnostic codes, the lag time of weeks to months to get paid anything, laws against balance billing, laws limiting lab testing, FKG interpretations, not to mention the crazy position you're put in as a doctor to both care for patients and worry whether insurance companies will pay you for

your services—that it is going to take a complete dismantling of the system before any of it makes sense. It's insane out there, and the sad thing is that internists are driving themselves to states of hypertension and near financial collapse in order to provide decent care to people who need it most.

My heart goes out to docs still in practice. I share with them the battle scars of combat, but like that song from the 1960s, "What Do You Get When You Fall in Love?":

"Don't tell me what it's all about, 'cause I've been there and I'm glad I'm out!" ❧

Right

"The Donna Reed Show"
1958-1966 ABC
Carl Betz as Dr. Alex Stone
with a young patient.

Far right

"Julia"
1968-1971 NBC
Lurene Tuttle as
Headnurse Hannah Yarby,
Diahann Carroll as Julia
Baker and Lloyd Noland as
Dr. Chegley.



Personality Photos Inc.



Personality Photos Inc.

As Seen on TV



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Far left

"Star Trek"
1966-1969 NBC
DeForrest Kelley as Dr.
Leonard (Bones) McCoy.

Left

"Doctor, Doctor"
1989-1991 (off and on,
mostly off) CBS
Beau Gravitte as Dr. Grant
Lenowitz, Julius Carry III
as Dr. Abe Butterfield,
Maureen Mueller as Dr.
Dierdre Bennett, Matt
Flewer as Dr. Mike
Stratford and Tony
Carreiro as Dr. Stratford's
gay brother.

Above

"Marcus Welby M.D."
1969-1976
Robert Young as Dr.
Welby, Elena Verdugo as
Consuela Lopez and James
Brolin as Dr. Steve Kiley.

WELCOME
TO
CICELY, ALASKA
POP. 214 215 ELEV. 6,572



Left

"Northern Exposure"
from 1990 CBS
Rob Morrow as Dr. Joel
Fleischman.

Below

"The Bob Newhart Show"
1972-1978 CBS
Peter Bonerz as Dr. Jerry
Robinson, guest star Tom
Poston and Bob Newhart as
psychologist Bob Hartley.

Below, bottom

"The Cosby Show"
from 1984 NBC
Sonia Braga as a maternity
patient with Bill Cosby as Dr.
Cliff Huxtable.



Personality Photos Inc.

"I'm not a doctor, but I play one on TV," says Robert Young in a Sanka coffee commercial. Thus the authority of the fictional doc is juxtaposed with the real thing. Patients enter medical offices around the country with thoughts of Marcus Welby, Cliff Huxtable and Doogie Howser on their minds, and their satisfaction or dissatisfaction may be influenced by them. While this issue of the *Bulletin* is devoted to real-life private practitioners, we thought it might be fun to take a look at the competition—the prime-time practitioners.



Personality Photos Inc.

The Use of Force

A short story

by William Carlos Williams

THEY WERE NEW PATIENTS TO ME, ALL I HAD WAS THE name, Olson. Please come down as soon as you can, my daughter is very sick.

When I arrived I was met by the mother, a big startled looking woman, very clean and apologetic who merely said, Is this the doctor? and let me in. In the back, she added. You must excuse us, doctor, we have her in the kitchen where it is warm. It is very damp here sometimes.

The child was fully dressed and sitting on her father's lap near the kitchen table. He tried to get up, but I motioned for him not to bother, took off my overcoat and started to look things over. I could see that they were all very nervous, eyeing me up and down distrustfully. As often, in such cases, they weren't telling me more than they had to, it was up to me to tell them; that's why they were spending three dollars on me.

The child was fairly eating me up with her cold, steady eyes, and no expression to her face whatever. She did not move and seemed, inwardly, quiet; an unusually attractive little thing, and as strong as a heifer in appearance. But her face was flushed, she was breathing rapidly, and I realized that she had a high fever. She had magnificent blonde hair, in profusion. One of those picture children often reproduced in advertising leaflets and the photogravure sections of the Sunday papers.

She's had a fever for three days, began the father and we don't know what it comes from. My wife has given her things, you know, like people do, but it don't do no good.



Scott County, Missouri, February 1942; "Country doctor examining child in farmhouse"; photo taken by John Vachon. This is one of a quarter million photographs taken from 1935 to 1942, under the auspices of FDR's Farm Security Administration, by photographers who wandered the United States capturing ordinary people in everyday life. It is one of 80 photographs that John D. Stoeckle, '47 and George Abbott White selected for *Plain Pictures of Plain Doctoring* (MIT Press, 1985), photographs celebrated for very simply showing for the first time the everyday practice of medicine.

And there's been a lot of sickness around. So we tho't you'd better look her over and tell us what is the matter.

As doctors often do I took a trial shot at it as a point of departure. Has she had a sore throat?

Both parents answered me together, No . . . No, she says her throat don't hurt her.

Does your throat hurt you? added the mother to the child. But the little girl's expression didn't change nor did she move her eyes from my face.

Have you looked?

I tried to, said the mother, but I couldn't see.

As it happens we had been having a number of cases of diphtheria in the school to which this child went during that month and we were all, quite apparently, thinking of that, though no one had as yet spoken of the thing.

Well, I said, suppose we take a look at the throat first. I smiled in my best professional manner and asking for the child's first name I said, come on, Mathilda, open your mouth and let's take a look at your throat.

Nothing doing.

Aw, come on, I coaxed, just open your mouth wide and let me take a look. Look, I said opening both hands

wide, I haven't anything in my hands. Just open up and let me see.

Such a nice man, put in the mother. Look how kind he is to you. Come on, do what he tells you to. He won't hurt you.

At that I ground my teeth in disgust. If only they wouldn't use the word "hurt" I might be able to get somewhere. But I did not allow myself to be hurried or disturbed but speaking quietly and slowly I approached the child again.

As I moved my chair a little nearer suddenly with one catlike movement both her hands clawed instinctively for my eyes and she almost reached them too. In fact she knocked my glasses flying and they fell, though unbroken, several feet away from me on the kitchen floor.

Both the mother and father almost turned themselves inside out in embarrassment and apology. You bad girl, said the mother, taking her and shaking her by one arm. Look what you've done. The nice man . . .

For heaven's sake, I broke in. Don't call me a nice man to her. I'm here to look at her throat on the chance that she might have diphtheria and possibly die of it. But that's nothing to her. →

*Suddenly with one
catlike movement
both her hands
clawed instinctively
for my eyes and she
almost reached them
too.*

The Youngest Science

"Amity Street" from The Youngest Science: Notes of a Medicine Watcher by Lewis Thomas. Copyright © 1983 by Lewis Thomas. Used by permission of Viking Penguin, a division of Penguin Books USA Inc.



Lewis Thomas '37, chancellor of Memorial Sloan-Kettering Cancer Center in New York, is the author of three other books: The Lives of a Cell, winner of the 1974 National Book Award, The Medusa and the Snail (1974) and Et Cetera, Et Cetera (1990).

My father never had an office nurse or a secretary. The doorbell was answered by my mother or by whatever child was near at hand, or by my father if he was not involved with a patient. The office hours were one to two in the afternoon and seven to eight in the evening. I remember those numbers the way I remember old songs, from hearing my mother answering the telephone and, over and over again, repeating those hours to the callers: there was a comforting cadence in her voice, and it sounded like a song—one to two in the afternoon, seven to eight in the evening. The waiting room began to fill up an hour before the official office hours, and on busy days some of the patients had to

wait in their cars outside or stand on the front porch. Most days, my father saw ten patients in each hour; I suppose half of these were new patients, the other half people coming back to be checked from earlier visits.

Except for the office hours and quick meals, my father spent his hours on the road. In the early morning he made rounds at the local hospital, where, as chief of surgery, he would see the patients in the surgical wards as well as his own private patients. Later in the morning, and through the afternoon, he made his house calls. In his first years of practice, when he and my mother moved out from New York City to Flushing, which they picked because

Look here, I said to the child, we're going to look at your throat. You're old enough to understand what I'm saying. Will you open it now by yourself or shall we have to open it for you?

Not a move. Even her expression hadn't changed. Her breaths however were coming faster and faster. Then the battle began. I had to do it. I had to have a throat culture for her own protection. But first I told the parents that it was entirely up to them. I explained the danger but said that I would not insist on a throat examination so long as they would take the responsibility.

If you don't do what the doctor says you'll have to go to the hospital, the mother admonished her severely.

Oh yeah? I had to smile to myself. After all, I had already fallen in love with the savage brat, the parents were contemptible to me. In the ensuing struggle they grew more and more abject, crushed, exhausted while she surely rose to magnificent heights of insane fury of effort bred of her terror of me.

The father tried his best, and he was a big man but the fact that she was his daughter, his shame at her behavior and his dread of hurting her

made him release her just at the critical moment several times when I had almost achieved success, till I wanted to kill him. But his dread also that she might have diphtheria made him tell me to go on, go on though he himself was almost fainting, while the mother moved back and forth behind us raising and lowering her hands in an agony of apprehension.

Put her in front of you on your lap, I ordered, and hold both her wrists.

*Gripping the
wooden blade
between her molars
she reduced
it to splinters before
I could get it out
again.*

But as soon as he did the child let out a scream. Don't, you're hurting me. Let go of my hands. Let them go I tell you. Then she shrieked terrifyingly, hysterically. Stop it! Stop it! You're killing me!

Do you think she can stand it, doctor! said the mother.

You get out, said the husband to his wife. Do you want her to die of diphtheria?

Come on now, hold her, I said.

Then I grasped the child's head with my left hand and tried to get the wooden tongue depressor between her teeth. She fought, with clenched teeth, desperately! But now I also had grown furious—at a child. I tried to hold myself down but I couldn't. I know

it was a small country town with good trees and gardens but with the city still accessible by train, he had a bicycle, then a year later a horse and buggy, each of which he detested. A year or so before I was born, he had prospered enough to buy an automobile. First it was a Maxwell, which broke down a lot and kept him in a continual temper, then a snub-nosed Franklin sedan, finally a quite expensive Franklin coupe with a "modern" conventional front.

He spent the major part of his life in these cars, driving to the hospital and then around Flushing and through the neighboring towns, seeing one patient after another. He came home around nine or ten most evenings.

But it was at night, long after the family had gone to sleep, that my father's hardest work began. The telephone started ringing after midnight. I could hear it from my bedroom down the hall, and I could hear his voice, tired and muffled by sleep, asking for details, and then I could hear him hang up the phone in the dark; usually he would swear "Damnation," sometimes he was distressed enough to use flat-out "Damn it," or worse, "Damn"; rarely did I hear him say, in total fury, "God damn it." Then I could hear him heave out of bed, the sounds of dressing, lights on in the hall, and then his steps down the back stairs, out in the yard and into the car, and off on a house call. This happened every night at least once, some-

times three or four times.

I never learned, listening in the dark, what the calls were about. They always sounded urgent, and sometimes there were long conversations in which I could hear my father giving advice and saying he'd be in the next morning. More often he spoke briefly and then hung up and dressed. Some were for the delivery of babies. I remember that because of my mother's voice answering the phone even later at night, when he was off on his calls, saying that the doctor was out on a "confinement." But it was not all babies. Some were calls from the hospital, emergencies turning up late at night. Some were new patients in their homes, frightened by one or

another sudden illness. Some were people dying in their beds, or already dead in their beds. My father must have been called out for patients who were dying or dead a great many of his late nights.

Twenty years later, when I was on the faculty at Tulane Medical School and totally involved in the science of medicine, I had another close look at this side of doctoring. I had been asked to come to the annual meeting of a county medical society in the center of Mississippi, to deliver an address on antibiotics. The meeting was at the local hotel, and my host was the newly elected president of the society, a general practitioner in his forties, a successful physi-

how to expose a throat for inspection. And I did my best. When finally I got the wooden spatula behind the last teeth and just the point of it into the mouth cavity, she opened up for an instant but before I could see anything she came down again and gripping the wooden blade between her molars she reduced it to splinters before I could get it out again.

Aren't you ashamed, the mother yelled at her. Aren't you ashamed to act like that in front of the doctor?

Get me a smooth-handled spoon of some sort, I told the mother. We're going through with this. The child's mouth was already bleeding. Her tongue was cut and she was screaming in wild hysterical shrieks. Perhaps I should have desisted and come back in an hour or more. No doubt it would have been better. But I have seen at least two children lying dead in bed of neglect in such cases, and feeling that I must get a diagnosis now or never I went at it again. But the worst of it was that I too had got beyond reason. I could have torn the child apart in my own fury and enjoyed it. It was a pleasure to attack her. My face was burning with it.

The damned little brat must be protected against her own idiocy, one

says to one's self at such times. Others must be protected against her. It is social necessity. And all these things are true. But a blind fury, a feeling of adult shame, bred of a longing for muscular release are the operatives. One goes on to the end.

In a final unreasoning assault I overpowered the child's neck and jaws. I forced the heavy silver spoon back of her teeth and down her throat till she gagged. And there it was—hoth tonsils covered with membrane. She had fought

valiantly to keep me from knowing her secret. She had been hiding that sore throat for three days at least and lying to her parents in order to escape just such an outcome as this.

Now truly she was furious. She had been on the defensive before but now she attacked. Tried to get off her father's lap and fly at me while tears of defeat blinded her eyes. ❖

*She had been hiding
that sore throat for
three days at least by
lying to her parents
in order to escape
just such an outcome
as this.*

William Carlos Williams (1883-1963) was a physician whose patients were the poor and working class of Rutherford, New Jersey during the 1930s. He was also a writer, producing an enormous amount of work, including poetry, novels and short stories, much of which received critical acclaim only late in his life, or after his death. Among his most noted works is Pictures from Brueghel, for which he received the Pulitzer Prize posthumously. This story was written in 1938.

From the book William Carlos Williams: The Doctor Stories, compiled and with an introduction by Robert Coles. Copyright © 1984 by Robert Coles. Reprinted by permission of New Directions Publishers.

cian whose career was to be capped that evening, after the banquet, by his inauguration; to be the president of the county medical society was a major honor in that part of the world. During the dinner he was called to the telephone and came back to the head table a few minutes later to apologize; he had an emergency call to make. The dinner progressed, the ceremony of his induction as president was conducted awkwardly in his absence, I made my speech, the evening ended, and just as the people were going out the door he reappeared, looking harassed and tired. I asked him what the call had been. It was an old woman, he said, a patient he'd looked after for years; early that evening she had died, that was the tele-

phone call. He knew the family was in distress and needed him, he said, so he had to go. He was sorry to have missed the evening, he had looked forward to it all year, but some things can't be helped, he said. This was in the early 1950s, when medicine was turning into a science, but the old art was still in place.

I'd Do It All Again

by Rial W. Cummings

IN A FEW MONTHS, IT WILL BE 40 years since I graduated from Harvard Medical School. Since then, I have experienced two distinct careers.

The first, a 10-year stint, still vivid, was a wide-ranging, old-fashioned general practice in Shelby, Montana—a rowdy farming and oil town on the bleak plains east of Glacier National Park near the Canadian border. I was one of four doctors serving a county of 8,000 people, and the nearest comprehensive medical center was in Great Falls, a two-hour drive to the south. When blizzards roared down from Canada, we might as well have been in Nome, Alaska.

The second career, much longer but more prosaic, was and continues to be a busy family practice in Sunnyvale, California, the heart of “Silicon Valley”—chief site of the computer revolution and one of the most dynamic areas in the United States over the past 30 years.

I was born in a village in eastern Montana in 1923, son of a farmer turned high school superintendent. My childhood was surprisingly similar to that of my mother, born in 1900, a child of the new century. She was the youngest of 10 children in a nomadic family who wandered westward from Minnesota to Saskatchewan and ultimately Montana.

We still had outdoor toilets and bedroom chamber pots for nocturnal use in winter. Drinking water, strongly alkaline, came from our well, and we drank from a pail and dipper in the kitchen. I remember kerosene lamps and Coleman gas lanterns. Later, we did have electric lights, three to five hours each night, depending on the



Rial W. Cummings '52 is in family practice in Sunnyvale, California. (Aesculapiad photo, 1952.)

season. We had no telephones and a telegram meant a critical illness or death in the family. But enough of this. I never felt deprived. How lucky can a kid get—only on Saturday night was I forced to take a real bath.

I must skip other details of my youth, but I can't resist mentioning that my maternal grandfather eked out a living operating a livery stable, and my best friend's father was an honest-to-God blacksmith, hammering on plowshares. And indeed, his arms were brawny.

I witnessed three medical events that may have influenced me later. My younger sister had a close call with a ruptured appendix; my father barely survived a desperate, four-week battle with pneumococcal pneumonia; and a classmate nearly died of tetanus—I can still see him writhing in opisthotonos.

After graduating from HMS, I married my college sweetheart, a pharmacist, and served a surgical internship at

Stanford University Hospital. It was then 1953 and I was 29, impatient to move forward, but uncertain about the future. Everything came together in a wonderful year of general practice residency at Monterey County Hospital in Salinas, California. After a brief search, I began practicing in Shelby with a 53-year-old Texan, a personable spree alcoholic.

When we met, I asked him what he did, what his practice was like. “Well,” he said, “I don't operate on the eye if I can avoid it.” In other words, you name it, he did it.

It was a time of unparalleled optimism and confidence in this country. Even small towns were booming. Hopes were high, fees low. Office visits were \$3, hospital visits \$4. Charges in our new hospital—constructed with Hill-Burton funds and subsidized by the county—were \$10 a day. The fee for prenatal care and delivery was \$75. Other charges were proportional and we prospered almost as much as a typical wheat farmer with government subsidies. But we worked much harder!

In Shelby, you came to the doctor when you were hurt. A physical exam meant you were applying for insurance. Preventive medicine was just emerging and was confined to the occasional progressive woman who came in for a Pap smear and examination.

Almost daily, something punctuated our routine: a delivery, a farm accident, a fracture, an unscheduled surgery or an acute serious medical illness.

My partner also provided more than his share of uncertainty and excitement. John taught me a lot about surgery—and more about life. He was a sporting man. He loved the fights and

the horses. I particularly remember a call from New York City where he'd attended a heavyweight championship bout. "Rial," he drawled long distance, "how much we got in the account?" When I told him about \$1,400, he said: "Can you wire me a quick seven? They ran mighty sorry at Belmont today."

Of the four or five most memorable experiences in Shelby, one, a tragedy, still haunts me. A 22-year-old woman rolled her pickup and died of a ruptured spleen 16 hours later, a casualty of my inexperience and indecision. She was injured early one morning, survived the splenectomy that evening, but died several hours later in irreversible shock despite massive blood transfusions. If I had operated earlier, I am convinced I could have saved her life. Ironically, her father, the local railroad station master, was a close friend of my father's brother.

A few years later, under similar circumstances, I was able to successfully repair a lacerated liver suffered by a young Canadian girl. But somehow it never quite assuaged my guilt.

After a record four-year association—none of John's previous partners had survived even two years—I reluctantly dissolved our partnership. John left for further adventures. I am happy to say, however, that he eventually conquered his drinking and spent his last years productively back in his native Texas.

I was sued for malpractice in 1960. The case spoke for itself, *res ipsa loquitur*, in legal terms. While performing a post-delivery tubal ligation on a massively obese patient, I lost a large lap sponge in the abdomen. Some months later, she saw a doctor in a nearby town. An x-ray showed the offending foreign body and further surgery relieved her chronic pain.

My liability insurance with Lloyd's of London contained an obscure clause stating that any procedure involving sterilization was not covered. I felt guilty and frightened, my self-confidence threatened.

Most towns had a local Clarence

Darrow, and Shelby, a county seat, was no exception. Because the victim was a Blackfoot Indian, "Clarence" advised me not to settle, since no local jury would award her more than minimal damages. I ignored his advice and hired an amiable, less aggressive attorney, who settled after extensive negotiations. Lloyd's and I paid \$10,000 each,

Whenever a physician says he is glad none of his children entered medicine, I feel sorry for him.

and the hospital paid \$5,000. I'd made a mistake and she deserved the money, a considerable amount at that time. I hope it enabled her family to achieve a better financial status.

When my younger brother Dean, an internist from Columbia Physicians & Surgeons, married a nurse from California, I moved with my wife and four young children to join them. After combing the state, we settled on Sunnyvale. There was a superb new hospital where I immediately recognized four old friends, two from HMS and two from Stanford.

We started fast, splitting a 40-hour week at Lockheed, a giant aerospace and defense facility, while building our private practice. Initially, Dean's wife was our sole employee.

Lockheed, which I left after the first year, was riddled with bureaucratic inefficiency. Though scheduled to perform four executive physical examinations a day, it was rare for my brother and I to complete more than one apiece. The managers, involved in endless meetings, missed many appointments. The high incidence of heavy smoking, alcoholism and liver disease among middle and upper managers

alarmed me. I started thinking about the importance of preventive medicine, rather than crisis intervention, which still dominated our profession.

In addition to my growing practice, I worked a weekly 24-hour shift in the hospital emergency room. A few years later, it was reduced to 12 hours because of increased volume. I often worked all night followed by a full day in the office. I continued this schedule until 1984, when a full-time panel was organized. I gradually cut back on surgery and stopped delivering babies, but continued as a surgical assistant.

Though busy as ever, my practice has changed dramatically. Today, most of my work is preventive and acute outpatient medicine, minor surgery, health education and counseling. I refer many patients to specialists, but the rapport my patients and I have developed over the years often surprises and touches me. They almost always insist I be present during their surgery, no matter how minor my role. They seek my advice when facing serious, chronic medical illness.

Whenever a physician says he is glad none of his children entered medicine, I feel sorry for him, and find it hard to believe. Our profession, in spite of recent widely-known problems, is a great way to spend a life.

William A. Nolan, the late surgeon-writer, said his father, a struggling depression-era lawyer, often told him, "Billy, if you're smart when you grow up, you'll be a doctor. Those bastards have it made."

That sounds a little strong, but we are certainly privileged. We can practice wherever we choose, work long or moderate hours, are generally well paid, enjoy more autonomy than most professions, and receive the respect and often admiration of our patients.

If I had it to do all over again, with a few minor changes, I'd do it again. 25

Where Everyone Knows Your Name

by Craig Yorke

COMMUNITY PRACTICE IS NOT SO special or unusual. All of us who practice work in communities. The university hospital community is well known to us all from our training. It included those with whom we learned and matured—a community of students and teachers.

Some of us have chosen to work in a more general community. Since 1980 I've been a neurosurgeon in Topeka, Kansas, a city of about 150,000. I've been supported by my community and have been accountable to it in ways I would not have anticipated.

I learned in training that few of us can be both excellent in surgery and creative in research. I was privileged to do basic research and to experience the ecstatic excitement that comes with the creation of new information. I later learned that such experiences are rare. I learned that surgical indications come under pressure in an environment oversupplied with surgeons—that superfluous surgeons tend to do superfluous operations.

But I learned also that the best surgeons operate frequently. And I aimed to become such a surgeon. I looked for a simple environment in which I could do first-rate work. And I looked for peers I could enjoy and respect. I found a measure of both in Topeka.

Even so, I came to a very active clinical practice in eastern Kansas with major ambivalence. My background was entirely urban, my training highly academic, and my resident peers dis-



Craig Yorke '74 is a neurosurgeon in Topeka, Kansas. (Aesculapiad photo, 1974.)

missive of such a community practice. My self-image still has its occasional bad moments based on my own lingering regional biases.

What I have found, though, is a major challenge: to lead a balanced life and maintain clinical excellence without a teaching hospital peer group. To meet this challenge is to experience major anxiety—and intense fulfillment. I am very necessary to this community. I have authority here. I'm known to the point of claustrophobia at the grocery store, the gas station and the mall. I've saved my share of lives, and those lives interact with my own every day.

I think particularly of a nurse whose solitary cerebellar breast metastasis was removed eight years ago, or of the ward clerk whose facial weakness

reminds me of the price paid for removing his acoustic neuroma. The ten-year-old red-haired boy next door was only five when he very nearly died of a ruptured occipital arteriovenous malformation. Like the rest of the neighborhood, I find myself forgetting that he ever had an operation.

I am personally accountable for my results in a way that is unique to surgery. An operation is a discrete and dramatic event in a patient's saga—an event with a discrete author. This authorship is magnified in a system without students and house staff. It is a system with few moving parts and a very direct accountability. I've been fortunate to work in a community small enough to evaluate its professionally by word of mouth. And I've had many, many intimate doctor/patient relationships over the past 11 years. This process has given me a reputation that I value greatly, one which will last until my next operation.

These are bad times for community doctors. Many of us are angry and frustrated. We are angry, I think, because our authority and our accountability are increasingly out of balance. We see major corporate organizations and government agencies exercising great power over all aspects of our patient care. But we also know that these agencies are not accountable for their actions. They are protected by distance, time and by the anonymity that group decisions convey.

Everyone in Topeka knows whom

to praise (or blame) for my surgical results. But how do we assign responsibility for an RBRVS (resource-based relative value scale) or a national health insurance system? If such systems fail, they don't fail immediately, and by the time they do, their creators have long since moved elsewhere in the bureaucracy, leaving their successors simply to repeat the process of collective creation.

We are accountable to our patients. We have powerful therapeutic tools. We can do spectacular things for our patients. But we cannot accept responsibility for the consequences of self-destructive lifestyles or for self-inflicted illness. We are accountable to rebut the medical consultants for *Ladies Home Journal* and *USA Today*, but lack the authority that comes with national publication.

However angry we are, we must continue to focus on our opportunities in the current health care crisis rather than so much on the dangers. We have opportunities to prove ourselves to our patients every day, to prove that we are worthy of the emulation of our most talented and principled young people, and that we are worthy of our elite status. We must focus on our opportunities because the alternative is not attractive to this aging America—a landscape of managers, insurers and administrators manipulating an increasingly mediocre and dispirited collection of health-care providers.

Personally, my decision to do community practice has been a good one. My skills are becoming broader, if not deeper. I now know something about small business administration, personnel management and local politics—topics not emphasized at HMS. Lacking skeptical residents, I teach my patients and my neighbors all they wish to know about the nervous system. These people have become special to me; my practice here reflects them and has become special as well. ❧



photo by Jerry Berndt

Shadowing

HMS students are finding out early what it's like to be a practitioner. In Doctor/Patient I, all first-year and, in Introduction to Clinical Medicine, about 40 second-year students are assigned to shadow a doctor. The students follow over 100 HMS teaching-instructors in their private offices, HMOs, health centers, VA outpatient clinics and hospital rounds to learn by watching, listening and discussing what goes on. To facilitate discussion of medical work, John Stoeckle '47, Larry Ronan '87 and Carol Ehrlich, instructors in the courses, constructed an outline of the work of care that doctors, patients and patients' families do.

The Work of Care

Information work: questioning/listening about physical complaints, feelings.

Body work: physical examination, imaging, machine testing, exercise, medication.

Emotional work: psychological diagnosis, communication of feelings.

Comfort work: personal support of patient in all stages of illness.

Negotiation and interpretation: defining the course that illness and care may take.

Education work: prevention of risks of diseases and disabilities.

Brokering work: scheduling tests, consultations, community services, arranging chronic care.

Moral or ethical work: therapeutic responsibility, patient advocacy, informed choices.

Collaborative colleague work: personal responsibility amid specialized professions.

Self-reflection work: improving practitioner/patient relations.

Developed by the Cabot Group for the Improvement of Ambulatory Care and Treatment

Salvatore Ruggiero '86 and John Stoeckle '47 with a patient.

The National Health Services Corps:

To a Healthier Nation

by Donald Weaver

THE NATIONAL HEALTH SERVICE Corps (NHSC) is alive and well and celebrating 20 years of placing primary care providers in rural and inner-city America to meet the needs of the underserved. Since 1972, the NHSC has placed over 16,000 primary care health professionals (including 13,397 physicians) in federally-designated health professional shortage areas (HPSAs).

Throughout its history, the NHSC has sought primary care providers who see both the individual and the community as "patients," people who can maximize the impact that the NHSC can have on the health status of the whole community. The NHSC continues to actively recruit health care professionals who blend the best principles of primary care and public health in a community-responsive practice setting. The program provides a unique opportunity for health care professionals, in conjunction with community members, to have a significant impact on the health status of the community.

The mission of the NHSC has been constant since its inception—to remove geographic and financial barriers to health care for those most in need. NHSC providers are required to see all patients without regard for their ability to pay. Each NHSC practice has a sliding fee scale, with a minimum fee, to



Donald L. Weaver '73 is director of the National Health Service Corps. (Aesculapiad photo, 1973.)

assure that financial barriers to access are removed, while still running a cost-efficient practice. While serving in the NHSC, providers may be salaried by a community-based not-for-profit corporation, a local or county health department, the federal government, or in private practice. Depending on specialty, the salaries range from \$60,000 to \$90,000 per year. The NHSC also tries to match providers with cultural backgrounds and language skills appropriate to the area.

From rural Maine to inner-city Detroit, from the Mississippi Delta to

the Lower Rio Grande Valley, and from East Los Angeles to the Pacific Basin, the NHSC is improving access to primary care services in areas that qualify for NHSC assistance. To be designated an HPSA, an area must have a physician to population ratio of 1:3,500 or greater. Dental HPSAs use a 1:5,000 ratio, while mental health HPSAs qualify with a 1:30,000 ratio. The Health Resources and Services Administration's Office of Shortage Designation determines HPSAs, and designated areas are annually prioritized to target the communities of greatest need.

Who are the underserved? The underserved include the pregnant woman in Appalachia who would have to travel over 100 miles for prenatal care if an NHSC provider had not been placed in her area. The underserved also include an elderly gentleman in the inner-city who now only has to transfer once on the way to an NHSC-staffed clinic. Migrant and seasonal farm workers and their families, who must move where crops are ready for planting or harvest, are also part of the underserved, as are homeless families, people infected with HIV, and individuals with substance abuse problems.

The history of the NHSC is fascinating, beginning with the development

and passage of the Emergency Health Personnel Act of 1970, which authorized its establishment, and is described in Eric Redman's *The Dance of Legislation*: "The National Health Service Corps (NHSC), Bergman continued, [Note: Abraham Bergman, MD, one of the original thinkers behind NHSC], would consist of idealistic, young doctors and other health workers—men and women who would serve voluntarily for two years or so in a 'doctor deficient' area, such as a slum or a remote farming community.... The purpose of this program, however, would not be to make poor people medically dependent on the government; the ultimate aim would be to encourage NHSC doctors to establish their own practices in needy communi-

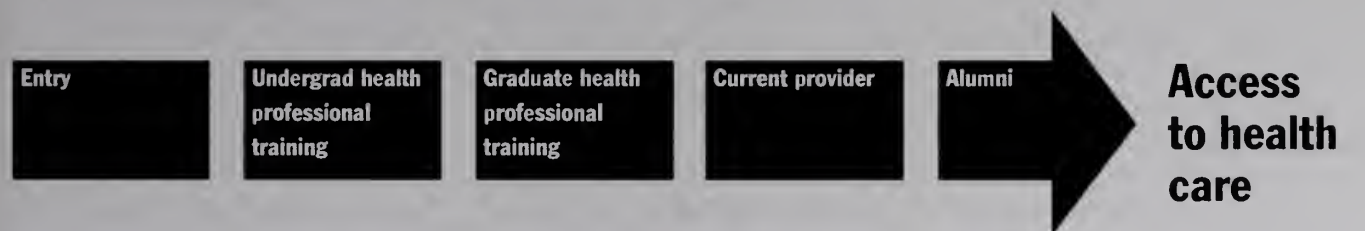
ties. Bergman believed strongly that at least some of the NHSC doctors would become 'sensitized' to the health needs of the poor, and that after their tours of duty in the corps were complete, these doctors would choose the psychic satisfaction of treating the needy over the financial rewards of practicing in more affluent communities. Bergman said, National Health Service Corps schemes were discussed increasingly in medical circles, both because such a corps was 'realistic' and because it could draw on the social commitment of young medical school graduates."

Originally the NHSC was composed of all volunteers. I began my career in the United States Public Health Service as one of those early volunteers, leaving Children's Hospital

Medical Center in 1975 for three challenging and exciting years in Tooele, Utah as an NHSC field assignee. As a member of the Family Practice Group of Tooele, I worked with two family physicians, a nurse practitioner, a physician's assistant, and a certified nurse midwife.

My experiences in Tooele were key components of my medical education. The 32-bed Tooele Valley Hospital was different in size and capability from the Harvard teaching hospitals where I had received my training, but all of these facilities shared the common vision of providing high quality care to people who needed service. The appreciation displayed by members of the community was the true reward of our practice.

The Continuum of Contact



Entry: The NHSC continues to foster linkages with the Health Careers Opportunity Program and other programs that encourage minority and disadvantaged individuals to pursue careers in the health professions. The program has established mentor networks for black and Hispanic medical students, linking interested students with primary care role models to assist them in their career preparation. The program continues to challenge educational institutions to have more community-oriented primary care providers as members of their admissions committees.

Undergraduate: The NHSC continues to sponsor and encourage student experiences in HPSAs. It was found that the more students taught in the ambulatory setting—developed to provide services to the underserved—the greater the likelihood that they will spend part or all of their careers serving this population.

Graduate: Just as for undergraduates, the NHSC will continue to sponsor resident and other graduate experiences.

Current providers: Those currently serving in the NHSC are the true role models. The program is committed to doing everything it can to support these individuals in providing primary care to the underserved. This support includes traditional continuing professional education, specially arranged continuing professional education based on needs identified in a particular practice, provision of locum tenens coverage, leadership and management training, networking with other providers serving those in need, linking with educational institutions for faculty appointments, as well as language and cross-cultural training.

Alumni: Along with enhanced efforts to identify program alumni to evaluate the success of the program, there are opportunities for alumni, and others, to serve as locum tenens, allowing current providers to get away from their practice for a period of time.



From an all-volunteer origin, the NHSC added a scholarship component in 1974 to increase the numbers of available health-care providers. In return for a scholarship—which pays tuition, fees and a monthly stipend—there is a year for year service obligation (with a minimum of two years). There has always been a buy-out provision, although the program's preference is for service rather than financial repayment. When it was felt that there were excessive numbers of buy-outs, the statute was changed to triple the amount plus interest owed the Federal Government.

The scholarship program has been a tremendous success. Of over 14,000 individuals who have participated in the program, 92 percent fulfilled their obligation, are currently serving, or are still in training.

The program continued to grow in the 1970s. However, in the early 1980s, there were several reports, including the Graduate Medical Education National Advisory Council report, that indicated that there would be an oversupply of physicians in the 1990s. Many felt that with an oversupply, "diffusion" would move physicians and other primary care providers into inner-city and rural America. Even though appropriations for the NHSC

decreased during the early and middle 1980s, 1985 saw the largest number of obligated scholars (1,600) become available for service because of the lag time between receipt of a scholarship and completion of a primary care training program. But the impact of the budget cuts was felt in the late 1980s to 1990, with almost a 50 percent reduction in field strength.

In the late 1980s, however, there was increasing consensus, including the Council on Graduate Medical Education, that even if there were an overall oversupply of physicians, there were not sufficient numbers in primary care, and health care providers were not diffusing into underserved areas. Given the limited resources of the program in the late 1980s, some modifications were made in the NHSC to meet the needs of the underserved.

In 1987, a loan repayment program was added to the NHSC to repay health professionals' loans in return for service in high priority HPSAs. Many felt that obligating medical students in their first and second years of medical school to a career in primary care through scholarships was not the optimal way to assure fulfillment of an obligation through service. With loan repayment, the NHSC could focus on recruiting those already committed to a

career in primary care to consider spending part or all of their professional careers serving those most in need. In 1988, a complementary State NHSC Loan Repayment program was begun, and is now active in 20 states.

In 1989 and 1990, a small, revitalized scholarship program was begun that added an interview as part of the selection process, assuring that those who accepted the scholarship clearly understood in person, as well as in writing, what obligation they were incurring and how they could best prepare themselves to serve the underserved as a community-oriented provider. Through this more personalized process, the NHSC was able to recruit a cadre of outstanding individuals: from former Peace Corps members, to individuals from underserved areas who wanted to return home, to those who were pursuing a career in a caring profession who wanted to "give something back to society."

A turning point came in 1990 when the NHSC came up for reauthorization, a process that would determine whether the program should continue. There was, and continues to be, increasing attention on meeting the health needs of all members of our society. "Healthy People 2000," the blueprint for a healthier nation by the end of the next decade, has as its general goals to increase the span of healthy life for Americans, reduce health disparities among Americans, and achieve access to preventive services for all Americans. With these goals in mind, and prevention being an integral part of primary care, the need for a reauthorized NHSC was evident.

Even the television and movie media recognized the needs of the underserved with "Northern Exposure" and *Doc Hollywood*. With support from the administration and both houses of Congress, the NHSC Revitalization Amendment of 1990 was passed, reauthorizing the NHSC through the year 2000. There was broad-based support for this reauthorization, acknowledging that some 35

million people reside in primary care HPSAs and that there are decreasing numbers of physicians choosing primary care. The National Advisory Council on the NHSC (NAC-NHSC), appointed by the secretary of the Department of Health and Human Services to advise him and the Congress, clearly recognized the need for a continued NHSC.

Anticipating that the NHSC would be reauthorized, the NAC-NHSC developed two position papers: "Proposed Strategies for Fulfilling Primary Care Manpower Needs" (February 1990), using family medicine as a paradigm; and "Proposed Strategies for Fulfilling Primary Care Professional Needs Part II: Nurse Practitioners, Physicians Assistants, and Certified Nurse Midwives" (August 1991). These position papers were based on several assumptions.

First, there are decreasing numbers of individuals pursuing careers in primary care and increasing numbers of service delivery systems, including the NHSC, who are recruiting from this limited pool. We must begin early in the educational process to attract more primary care health professionals, and remain in contact with these students through their lifetime of learning.

The NHSC has developed a six-point strategy for the next decade:

- The NHSC will continue to focus on the team approach to primary care, utilizing primary care physicians, nurse practitioners, physicians assistants, certified nurse midwives, dentists, mental health, and other health professionals.
- The HPSAs of greatest need will continue to be prioritized using physician to population ratios, poverty, infant mortality/low birth weight, and access to include distance as factors. Additionally, the program will be updating dental and mental health HPSAs on a systematic basis to determine how best to target resources to these needy areas.
- Retaining primary care providers in service to the underserved will be an integral part of meeting the needs of



photo by Paul Fellers

the future. An increasingly important objective of the program's recruitment efforts will be to determine how to support committed providers working with the underserved.

- NHSC recruitment will be enhanced through an expanded NHSC Scholarship Program, Federal Loan Repayment Program and State Loan Repayment Program. The program will continue to recruit volunteer primary care providers, without obligation, to work in HPSAs. A new program sponsors individuals from an HPSA to pursue a career in primary care and return to that HPSA; called the Community Scholarship Program, it is funded by a federal-state-local partnership, and will be entering its second year. This diverse portfolio affords the NHSC some flexibility in meeting the short- and long-term needs of the underserved.

- The NHSC will be seeking to expand its partnerships with communities, states, educational institutions, foundations, and other organizations who are interested in improving access to care to underserved populations.

- The NHSC will do everything possible to implement the strategy outlined by the NAC-NHSC and the new legislation, summarized as the Continuum of Contact (see sidebar), with the goal of

improving access to primary care services.

I must admit, I had not planned a career in the Public Health Service when I volunteered for the NHSC in 1975. I thought I would spend two years serving a needy community, to give something back and to gain experience in "front line" primary care. Two years in Utah turned into three, and other opportunities in the service delivery and health professions programs of the PHSC have shaped my career plans. Returning to the NHSC as director is truly "coming home."

Providing care to the underserved through the appropriate placement of primary care health professionals continues to be a challenge. Building on its proud past, the NHSC will meet the challenges of the next decade as a partner with anyone interested in realizing the dream of assuring access to primary care services to all members of our society. ❖

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